

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home Inc</u>						d. STREET ADDRESS <u>107, E Green Street</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Corra Elizabeth Adams</u>						<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>3</u> Year <u>1967</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 4, 1895</u>		<b>9. AGE</b> (in years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Legal Secretary</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Carroll County Westminster</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Charles Louis Adams</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Anne Appler</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>						<b>16. SOCIAL SECURITY NO.</b> <u>212-03-5355</u>		<b>17. INFORMANT</b> <u>patient</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma to</u> <u>1967</u> DUE TO <u>Bones - primary source</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>undetermined</u> DUE TO (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 Mon</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>			
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>67</u> , to <u>Dec 3</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>Dec 1</u> , 19 <u>67</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>W H Foard</u>						<b>22b. DATE SIGNED</b> <u>12/3/67</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. H Foard M.D.</u>						<b>22d. ADDRESS</b> <u>25 N. Main St</u> <u>Manchester, Md 21102</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>			<b>23b. DATE THEREOF</b> <u>12/6/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. John's CATH. CEMETERY</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>WESTMINSTER, MD.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>J. S. Myers, Jr., Westminster, Md, 21157</u>						<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>DEC 6 1967</u> <u>J Charles Judge</u>					

10/22  
Carrall

Weyland  
Westminster

Take 2 days

Carrall

Weyland

101 E Green Street

Long Run Housing Home Inc

10/22

Weyland

Take 2 days

Weyland

10/22

Carrall

Weyland

Take 2 days

Weyland

Take 2 days

Weyland

Take 2 days

Weyland

10/22

Weyland

Take 2 days

Weyland

Weyland

10/22

Weyland

Take 2 days

Weyland

Weyland

10/22

Weyland

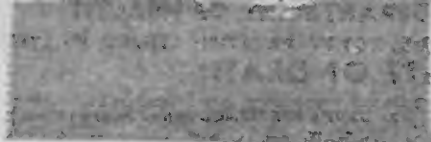
Weyland

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VR A15 (1)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>			d. STREET ADDRESS <u>P.O. Route # 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>M.</u> Last <u>Angell</u>					4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1882</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Abraham Hahn</u>					14. MOTHER'S MAIDEN NAME <u>Amanda Sowers</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>205-16-3890</u>		17. INFORMANT <u>R#2 Taneytown, Md.</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 4201 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u> <u>10 yrs.</u> <u>20 yrs.</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> <u>1967</u> to <u>12/23</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> <u>1967</u> , and that death occurred <u>12:00 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>R. S. McVaugh</u>					22b. DATE SIGNED <u>12/23/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>R. S. McVaugh</u>					22d. ADDRESS <u>Taneytown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Keysville Cemetery</u>		23d. LOCATION (City, town or county) <u>Keysville, Maryland</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Skiles</u>					25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
C.O. Fuss & Son <u>John M. Skiles</u>					Taneytown, Md.				

MEDICAL CERTIFICATION



## CERTIFICATE OF DEATH

16759

16754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home Inc</u>		d. STREET ADDRESS <u>Shalk Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Sophie</u> Middle <u>Baues</u> Last <u>Baues</u>		4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Otto</u>		14. MOTHER'S MAIDEN NAME <u>Catherine May Schaffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-52-1336</u>	
17. INFORMANT Address <u>Mrs Theresa Klein, Millers, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>67</u> , to <u>12/11</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>12/8</u> , 19 <u>67</u> , and that death occurred at <u>4:25 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W.H. Foard</u>		22b. DATE SIGNED <u>12/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H. Foard M.D.</u>		22d. ADDRESS <u>Manchester, Md 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-14-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

1875

Cornell

Muskrat

Longman Hunting Home Inc

4 muskrats

Sepher

Boars

Female white

X

Housewife

Henry Otto

Baltimore City, Maryland

Catherine May Schaffer

218-2-1234 Mr. Thos. Klein, Miller, Maryland

Jan 9, 1882

82

December 11, 81

Maryland

Miller

Shelt Road

Cornell



1  
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16755

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home Inc</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANOVER</u> d. STREET ADDRESS <u>RD # I</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Virginia</u> Last <u>Bierkamp</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shenandoah Co Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Strounider</u>		14. MOTHER'S MAIDEN NAME <u>  </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>185-28-4847</u>	
17. INFORMANT <u>Mrs Charles Watson</u>		Address <u>RD #1, Hanover, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 12</u> , 19 <u>62</u> , to <u>Dec 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 30</u> 19 <u>67</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush MD</u>		22b. DATE SIGNED <u>12-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hanover York Penna.</u>
24. FUNERAL DIRECTOR <u>Robert Kyle Orth Jr.</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>	
ADDRESS <u>Kitchmiller, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1951

Conall

1947-1948

2 years

long time during those two

Penelope

1947-1948

R.D. #1

X

Rose

Virginia

1947-1948

1947-1948

Frank White

X

1947-1948

Hester

1947-1948

1947-1948

William Stroud

1947-1948

1947-1948

William Stroud

X

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948

1947-1948



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16761

CERTIFICATE OF DEATH

16756

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CITY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. LENGTH OF STAY IN 1b <b>5 yrs 9 mo 5 da</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>909 Watson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>NMN</b> Last <b>BLUM</b>			4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03/10/1893</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland BALTIMORE</b>	
13. FATHER'S NAME <b>Jacob Blum</b>			14. MOTHER'S MAIDEN NAME <b>Sophia</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-8835</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Respiratory Infection</b>					INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>yrs.</b> <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS assoc. with cerebral arteriosclerosis with psychotic reaction</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>3/2/62</b> , 19 <b>62</b> , to <b>12/7/</b> , 19 <b>67</b> , that <del>the</del> (we) last saw the deceased alive on <b>12/7/</b> , 19 <b>67</b> , and that death occurred at <b>8:50</b> M, from causes and on the date stated above					
22a. SIGNATURE <b>Rafi Q. Iqbal</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rafi Q. Iqbal, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-11-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OHEB SHALOM</b>	
				23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 12 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16763					10751						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Carroll</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Union Mills, Md</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>						
c. LENGTH OF STAY IN 1b <u>1 week</u>					d. STREET ADDRESS <u>Houcksville Rd.</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Meadowview Nursing Home, Union Mills</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<u>Sebastian</u>				<u>Bodensteiner</u>		Month <u>12</u> Day <u>23</u> Year <u>1967</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern Owner</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas H Bodensteiner</u>					14. MOTHER'S MAIDEN NAME <u>Carrie Miller</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-30-3088</u>		17. INFORMANT <u>Mrs Margaret Mauck</u>			Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebrovascular hemorrhage</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>67</u> , to <u>12/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>67</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Julius Chepko</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>					22d. ADDRESS <u>852 W. Green St., Westminster, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc.</u>					ADDRESS <u>5305 Harford Rd</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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1. PLACE OF DEATH e. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm.) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. LENGTH OF STAY IN lb <b>14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Union Bridge Route #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		d. STREET ADDRESS <b>Route #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Agnes Bostian</b>		4. DATE OF DEATH Month Day Year <b>12 8 1967</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>October 28, 1909</b>		9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR Months Days <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>registered nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Horace Bostian</b>		14. MOTHER'S MAIDEN NAME <b>Lottie Biehl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-7662</b>		17. INFORMANT <b>Charles Bostian</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>2 WEEKS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>		20. YEARS <b>YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
22d. (City or town) <b>Westminster</b>		22e. (County) <b>Carroll</b>		22f. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11/24, 1967</b> to <b>12/8, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/8, 1967</b> , and that death occurred at <b>6:25</b> M. from the causes and on the date stated above.		22a. SIGNATURE <b>Vincent J. Fiocco, Jr.</b> M.D.		22b. DATE SIGNED <b>12/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Vincent J. Fiocco, Jr.</b>		22d. ADDRESS <b>Westminster, Maryland</b>			
23a. BURIAL, CREMATION, REMAINS (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Haughs Cemetery</b>	
23d. LOCATION (City, town or county) <b>Ladiesburg</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Fisher Sons Union Bridge Md.</b>		24a. ADDRESS <b>Union Bridge Md.</b>		24b. REC'D BY REGISTRAR <b>DEC 11 1967</b>	
24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24d. (State) <b>Md.</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. # 1</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> d. STREET ADDRESS <u>Rt. # 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY</u>		First Middle Last <u>C. BOWMAN</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Dec. 23, 1967</u> <u>19</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 12, 1884</u>			
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>		<b>13. FATHER'S NAME</b> <u>SAMUEL J. LEIZEAR</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ISABEL SULLIVAN</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-26-0265-D</u>		<b>17. INFORMANT</b> <u>S. Edward Bowman Item # 2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alveolar cell carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 mo.</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JAN 11</u> <u>1967</u> <b>to</b> <u>NOW</u> <b>19</b> , that (I) (we) last saw the deceased alive on <u>Dec 23</u> <u>1967</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above							
<b>22a. SIGNATURE</b> <u>J. H. Caricofe</u>				<b>22b. DATE SIGNED</b> <u>Dec 23, 67</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>J. H. Caricofe, M.D.</u>				<b>22d. ADDRESS</b> <u>Union Bridge, Maryland 21791</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/27/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Sunshine, Maryland</u>		<b>(State)</b>		<b>25a. REC'D BY REGISTRAR</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler Funeral Home, Rockville, Md.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>DEC 29 1967</u>			

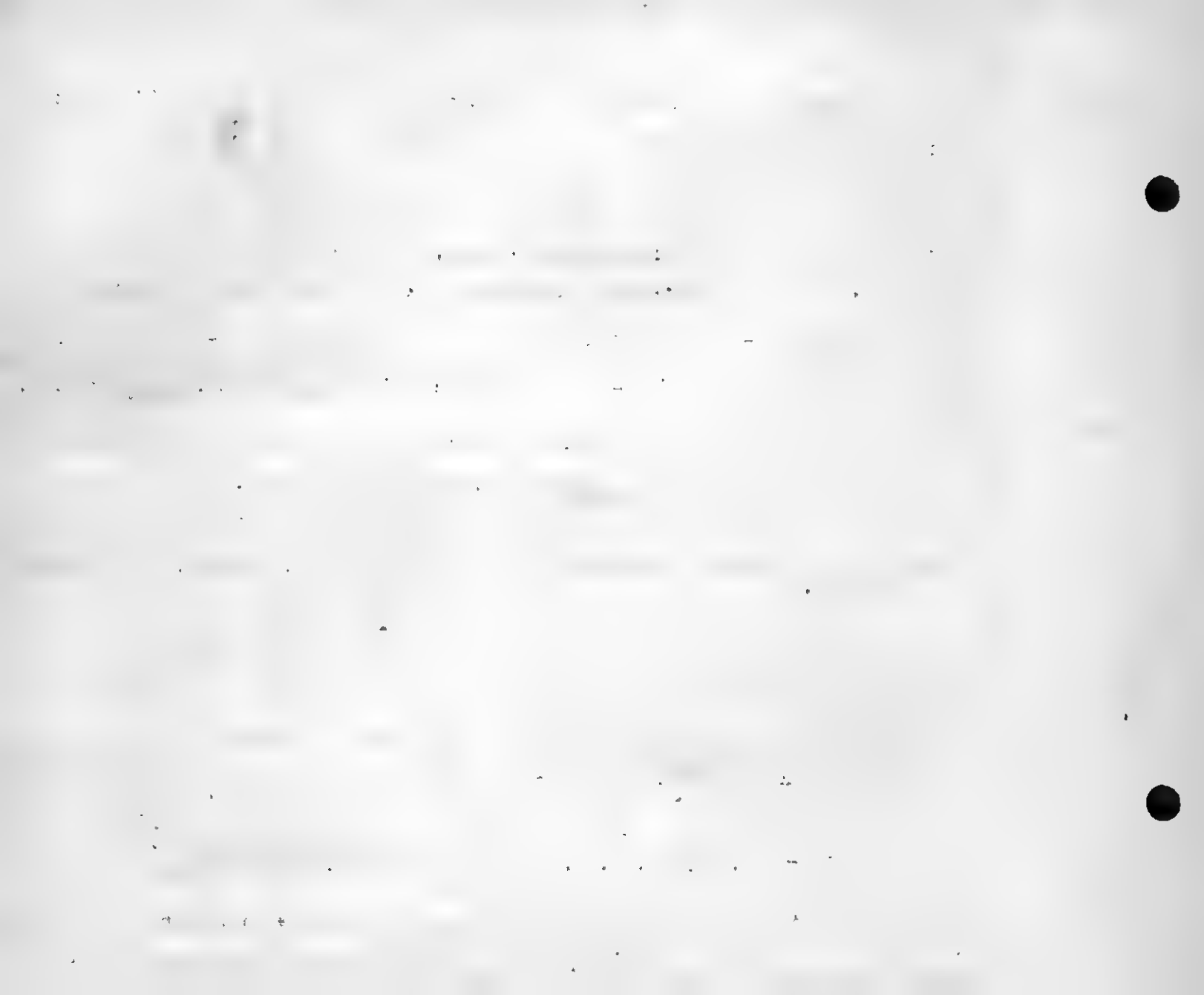


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16765										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16760																													
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR																													
First Middle Last <b>Bessie Alice Brooks</b>										12 Month 14 Day 67 Year										8:00am																													
3. SEX <b>female</b>										4. RACE <b>white</b>										5. DATE OF BIRTH <b>9/20/83</b>										6. AGE last b. YRS. MONTHS DAYS <b>84 2 24</b>																			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <b>Carroll</b>																			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>										12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) <b>Secretary</b>										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>										13b. COUNTY <b>Allegany</b>										13c. CITY OR TOWN <b>Cumberland</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <b>217 Davidson Street</b>									
14. FATHER'S NAME First Middle Last <b>Samuel - Dixon</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>Laura - Farrell</b>										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> No										16b. SOCIAL SECURITY NO <b>213-12-9996</b>										17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>										years																													
										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</b>																																							
										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>9/26/1967</b> , to <b>12/14/1967</b> , that <del>the</del> (we) lost saw the deceased alive on <b>12/14/1967</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did) <del>not</del> view the body after death.																																																	
22b. SIGNATURE <b>Renato R. Espina, M.D.</b>										22c. DATE SIGNED <b>12/14/67</b>										22d. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>										22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>										23b. DATE <b>Dec. 16, 1967</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>										23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>																			
24. FUNERAL DIRECTOR <b>Right Funeral Home</b>										25a. REC'D BY REGISTRAR <b>Charles J. Jones</b>										25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>										DATE <b>DEC 18 1967</b>																			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
16766									
CERTIFICATE OF DEATH									
16761									
1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Res. den. before adm. ssion) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Long View Nursing Home, Inc.</b>					a. STREET ADDRESS <b>211 South Main Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>A.</b> Last <b>BROWN</b>					4 DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 17, 1883</b>		9. AGE (In years last birthday) <b>84</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Greenmount, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George F. Face</b>					14. MOTHER'S MAIDEN NAME <b>Madella Hare</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>218-54-4659</b>		17. INFORMANT Address <b>Mrs. Miriam Hollman - Manchester, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>443A</b> IMMEDIATE CAUSE (a) <b>Hypertension C.V. Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>Arterio Sclerosis</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>12-22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-21</b> , 19 <b>67</b> , and that death occurred at <b>11:45</b> AM, from causes and on the date stated above.									
22a. SIGNATURE <b>M.C. Porterfield</b>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12-22-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>M.C. Porterfield</b>					22d. ADDRESS <b>Hampstead, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll County, Md.</b>		
24. FUNERAL DIRECTOR <b>Tipton- Eline Funeral Home, Hampstead, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>DEC 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		



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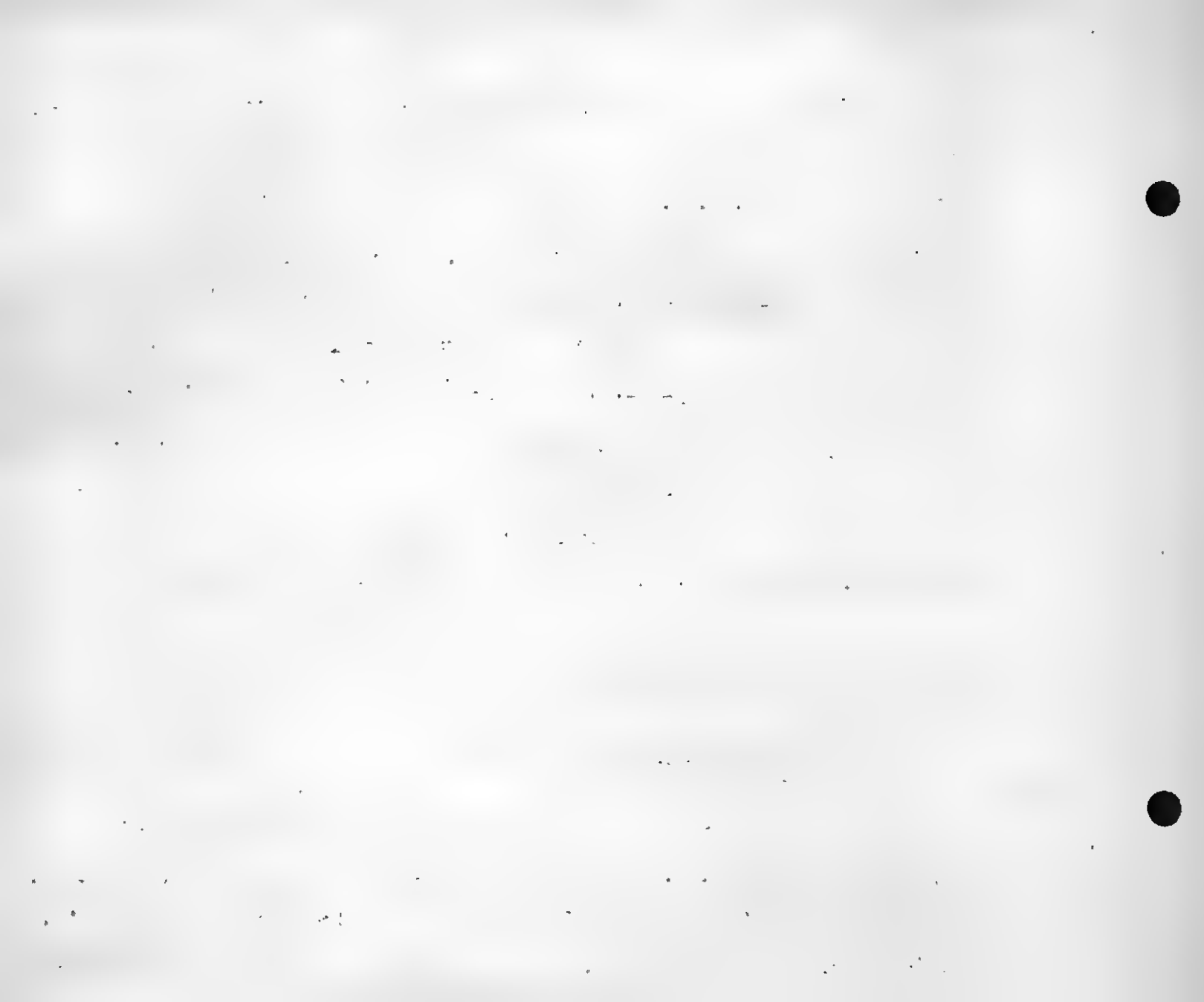
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113 (4)  
30M REV 4-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
CHARLES			BENJAMIN FRANKLIN BUTLER			Month Day Year 12 26 67			5:30 P M
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		01/03/99		68 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Carroll County Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Sykesville			Springfield State Hosp.			trackman/B&O RR			Railroad
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Allegany County		Cumberland				Springdale Street
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John Bubler			Laura Showacre						
16a. WAS DECEASED EVER IN U.S. ARMED SERVICES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT				
No			705-09-7045		Springfield State Hosp. Hospital Records Sykesville, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u>									days
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
CBS assoc. with Brain Trauma, gross force, with psychotic reaction; Alcoholism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11/24</u> , 19 <u>59</u> , to <u>12/26</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12/26/67</u> , 19 <u>67</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
Suha Ozgun.									12/26/67
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Suha Ozgun, M. D.					Springfield State Hospital, Sykes., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/29/67		Rose Hill Cemetery		Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
H. Wayne George Cumberland, Md.					DATE JAN 3 1968		John A. Judge		



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16763

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Md</u>		c. LENGTH OF STAY IN 1b <u>2 mos- 2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hosp. Sykesville</u>		d. STREET ADDRESS <u>3051 Pinewood Ave;</u>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>NMN</u> Last <u>Calzone</u>		4. DATE OF DEATH <u>Dec. 30</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-1900</u>
9. AGE (In years lost birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Anthony Venditti</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ferucci</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-03-6428</u>	
17. INFORMANT <u>Springfield State Hosp Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction (mins)</u> DUE TO (b) <u>Arteriosclerotic C V D (years)</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involuntional Psychotic Reaction-Diabetes Mellitus</u>		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 28</u> , 19 <u>67</u> to <u>Dec. 30</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Dec 30</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Dr. Antonius Glahn</u>		22b. DATE SIGNED <u>12-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Antonius Glahn</u>		22d. ADDRESS <u>Springfield State Hosp, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/3/68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc.</u>		25a. REC'D BY REG STRAR DATE <u>JAN 2 1968</u>	
25b. REG STRAR'S SIGNATURE <u>19-68</u>			



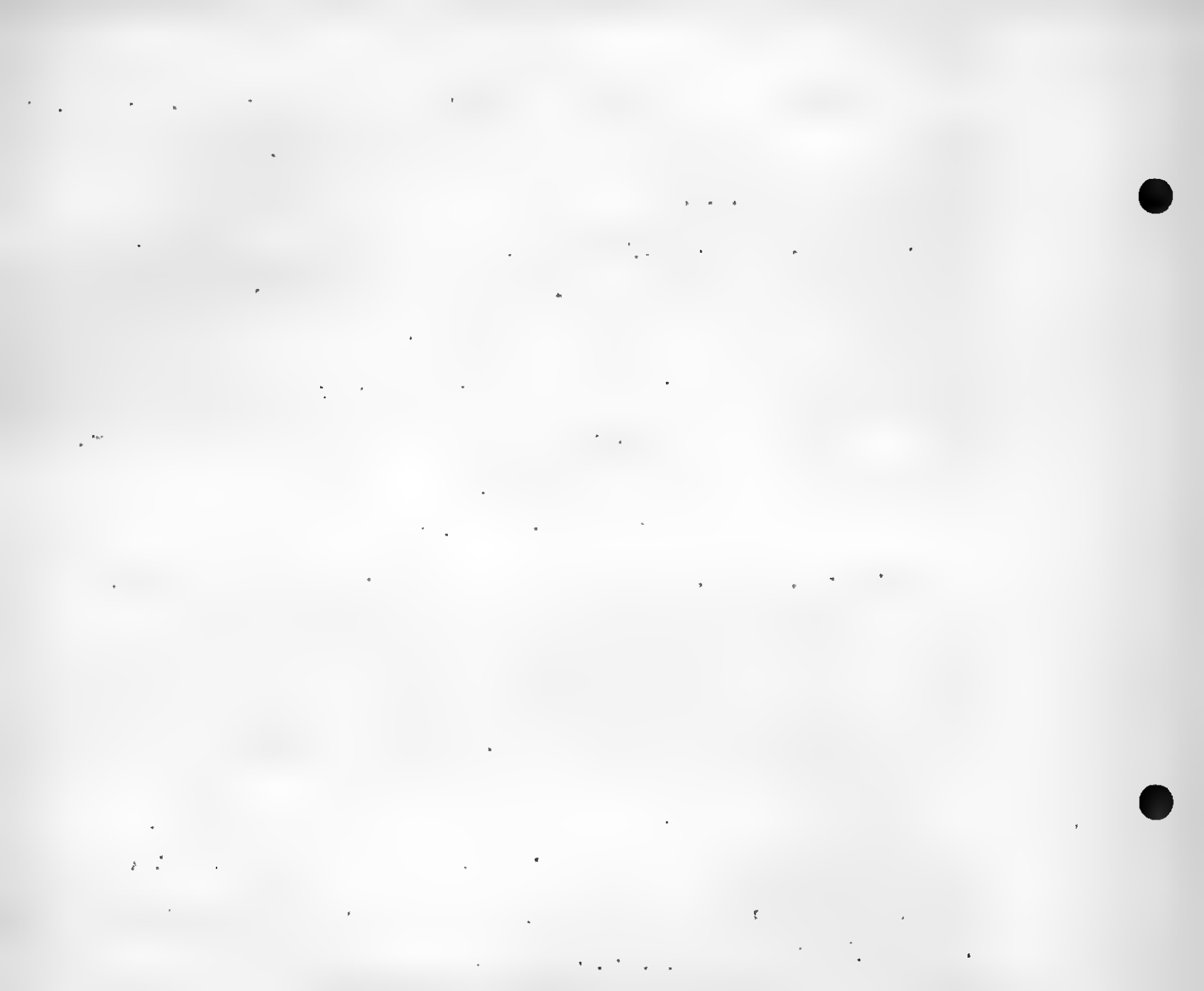


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VR A151  
30M RECH 7/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
CHARLES GARFIELD CRONE						12 20 67			2:45P M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		unknown		82 86 1/2 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland			U.S.A.				Carroll Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville, Md.			Springfield State Hosp			Farmer owner		farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Frederick		Brunswick				213 5th Street
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Edward ? Crone						Edith Ann ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
no			unk			Hospital record			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									hrs.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of the rectum</u>									months
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>CBS assoc. with cerebral arteriosclerosis without qualifying phrase</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.			21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <u>8/57</u> , 19 <u>63</u> , to <u>12/20</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arsenio Soriano, Jr.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12/20/67</u>	
22d. PHYSICIAN'S NAME (Type) <u>ARSENIO SORIANO, JR., M.D.</u>						22e. ADDRESS <u>Springfield State Hospital.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
burial			12/22/67		Reformed Cemetery		Middletown, Fredk., Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
<u>Gladhill Co. Middletown, Md.</u>						<u>DEC 26 1967</u>		<u>Charles Jones</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

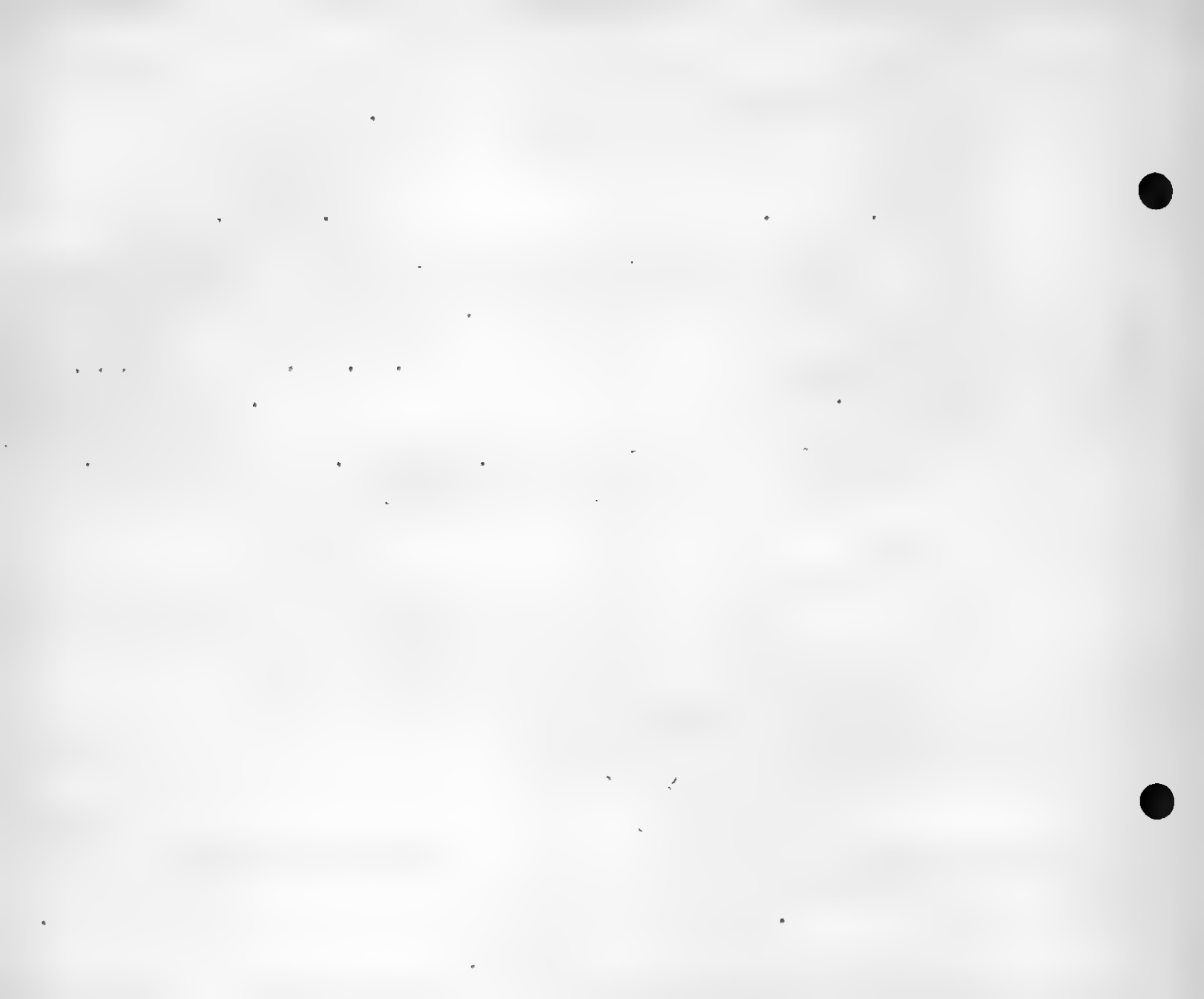
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16771

15766

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hampstead</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>316 N. Main St.</b>		d. STREET ADDRESS <b>316 N. Main St.</b>	
3 NAME OF DECEASED (Type or print) <b>VERNON ELWOOD CULLISON</b>		4 DATE OF DEATH <b>12 - 23 19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <b>Jan. 14, 1905</b>
9 AGE (In years last birthday) <b>62</b>		10 IF UNDER 1 YEAR Months <b>12</b> Days <b>23</b> Hours <b>19</b> Min <b>67</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory Worker</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
12 BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		13 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14 FATHER'S NAME <b>Walter B. Cullison</b>		15 MOTHER'S MAIDEN NAME <b>Martha A. Martin</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		17. SOCIAL SECURITY NO. <b>217-01-8435</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Cerebral thromboses (acute) sudden</b> DUE TO (b) <b>stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>stroke</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>4</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. E. Specker</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>12-23-67</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>W. E. Specker</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 26, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Hampstead Carroll Co. Md.</b>
24 FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>		25a. REC'D BY REG. STR. <b>DEC 29 1967</b> DATE	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16769

16764

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Potomac</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Golden Age Trust Home</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Amy F. Creamer</i>		4. DATE OF DEATH Month <i>December</i> Day <i>14</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/9/74</i>
9. AGE (In years last birthday) <i>93</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (County & State or foreign country) <i>Frederick Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Amy Roberts - granddaughter - Darnestown, Maryland</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cerebral Vascular Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Cardiac disease</i> DUE TO (c) <i>Sinus Atrial Tachycardia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i> <i>18</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June 6, 1964</i> to <i>Dec 14, 1967</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>10</i> M, from causes and on the date stated above			
22a. SIGNATURE <i>M. M. AGTIN</i>		22b. DATE SIGNED <i>Dec 14-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. H. H. H.</i>		22d. ADDRESS <i>Westminster, Md.</i>	
23a. BURIAL, CREMATION, etc. (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/16/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Potomac</i>	23d. LOCATION (City or Town) (County) (State) <i>Potomac Montgomery Md.</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>		25a. REC'D BY REGISTRAR <i>DEC 21 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J.</i>		25c. REGISTRAR'S NAME <i>Charles J. J.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminister</u> c. LENGTH OF STAY IN 1b <u>unknown</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Westminister</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rt. 6 Box 208</u> d. STREET ADDRESS <u>Westminister</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles J. Davlin</u> First Middle Last 4. DATE OF DEATH <u>12 19 1967</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/3/1888</u> 9. AGE (In years last birthday) <u>79</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harford County, Md.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>USA</u> 11. PLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>John Davlin</u> 14. MOTHER'S MAIDEN NAME <u>Mary Price</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>579-05-1507</u> 17. INFORMANT <u>Mrs. Bernice Davlin</u> Address <u>Westminister, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (U) (this hospital) attended the deceased from <u>12/13</u> , 1967, to <u>12/19</u> , 1967, that (I) (we) last saw the deceased alive on <u>12/19</u> , 1967, and that death occurred at <u>4:20</u> A.M. from the causes and on the date stated above	
22a. SIGNATURE <u>Vincent J. Procco Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type)		22b. ADDRESS <u>12/19/67</u> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/22/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran, Inc.</u> 25. REC'D BY REGISTRAR <u>DEC 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville, Md.</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Rt. 2 Liberty Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2 Liberty Road</u>		e. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter (1881) Edmondson</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1883</u>
9. AGE (In years lost birthday) <u>84 yrs</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Edmondson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Grimes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>216 10 6353</u>	
17. INFORMANT <u>Mr. Charles Edmondson Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Chr. Myocarditis</u> DUE TO (c) <u>Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1964</u> , to <u>Dec 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 4, 1967</u> , and that death occurred at <u>5 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Gaston M.D.</u>		22b. DATE SIGNED <u>Dec 5-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Gaston M.D.</u>		22d. ADDRESS <u>Wilmington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Larry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>DEC 11 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16774

16769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b> c. LENGTH OF STAY IN 1b <b>2 mos. 22 da.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate lim'its, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3003 Wylie Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDNA LOUISE EISE</b>		4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-01</b>
9. AGE (In years last birthday) yrs <b>66</b>		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Typist</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Eise</b>		14. MOTHER'S M.A.DEN NAME <b>Harriet Tiedt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		18. ADDRESS <b>Sykesville, Maryland 21784</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic heart disease with congestive failure</b> DUE TO (c) <b>failure</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-15, 1967</b> to <b>12-7, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12-7, 1967</b> , and that death occurred at <b>3:30AM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		22b. DATE SIGNED <b>12-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CRAMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>12/9/67</b>	<b>Gravill Ridge</b>	<b>Sykesville Md</b>
24. FUNERAL DIRECTOR <b>Spring Byers</b>		25a. REC'D BY REGISTRAR <b>8728 Liberty Rd</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 11 1967</b>	



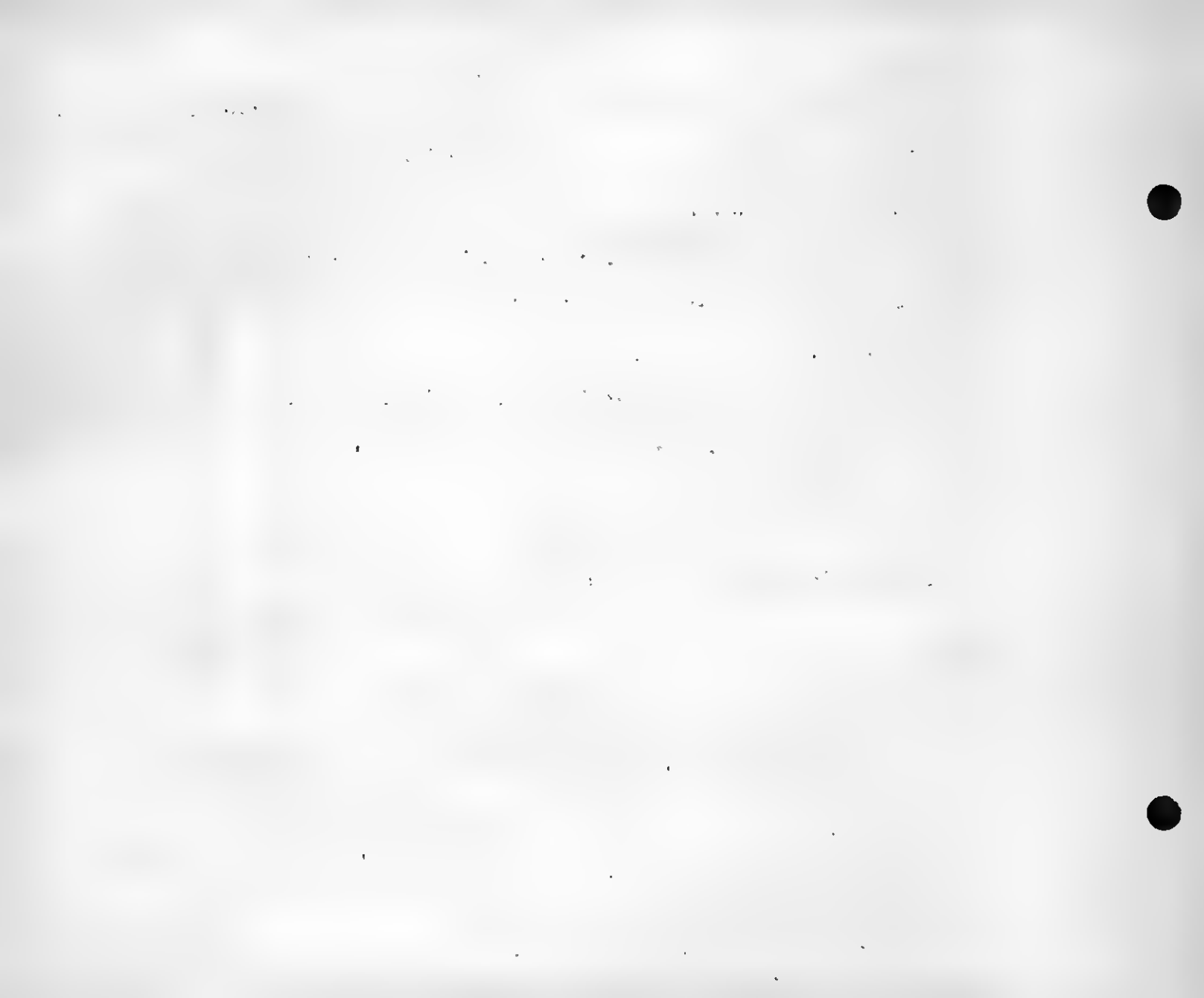


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>GERTRUDE ELIZABETH FORNEY</b>			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>29</b> Year <b>1967</b>		2b. HOUR <b>8:10</b> P M	
3. SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>11-27-1882</b>		6. AGE (In years last birthday) <b>85</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.		
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Westminster</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route #7</b>	
14. FATHER'S NAME First <b>Emanuel</b> Middle <b>-</b> Last <b>Forney</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>-</b> Last <b>Feesser</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-54-7592</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b> <b>443X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Schizophrenic reaction, paranoid type</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-31-58</b> , 19____, to <b>12-29-67</b> 19____, that (I) (we) last saw the deceased alive on <b>12-29-67</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Antonius Glahn, M. D.</b>		22c. DATE SIGNED <b>1-3-68</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Jan 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Md.</b>
24. FUNERAL DIRECTOR <b>Charles J. [Signature]</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10yrs. 19dys.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>-----</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>ELIZABETH</b> Last <b>FRANK</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1893</b>
9. AGE (In years last birthday) yrs. <b>74</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Zepp</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Carroll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-54-7124</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO (b) <b>Advanced generalized arteriosclerosis</b> DUE TO (c) <b>Chronic brain syndrome assoc. with convulsive disorder, with psychotic reaction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>+200</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Chronic brain syndrome assoc. with convulsive disorder, with psychotic reaction</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12-10-57</b> , 19 <b>67</b> , to <b>12-29-67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-29-67</b> , 19 <b>67</b> , and that death occurred at <b>6:10 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Antonius Glahn, M.D.</b>		22b. DATE SIGNED <b>12-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-30-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Freedom</b>	23d. LOCATION (City or Town) (County) (State) <b>Sykesville Md.</b>
24. FUNERAL DIRECTOR <b>Harry W. Haight Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16777

16771

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Long View Nursing Home</u>				d. STREET ADDRESS <u>63 Webster St</u>			
3 NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Lee</u> Last <u>Friese</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>6/21/1892</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife, also worked in dairy</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. Md., U.S.A.</u>	
13 FATHER'S NAME <u>James Dickenshuta</u>				14. MOTHER'S MAIDEN NAME <u>Laura J. Lescallot</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>189-07-1813</u>		17 INFORMANT <u>Bloyd A. Friese</u> Address <u>63 Webster St. Westminster, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>2 yrs</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Dec 6</u> , 19 <u>67</u> , to <u>Dec 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 26</u> , 19 <u>67</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Foward</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foward M.D.</u>				22d. ADDRESS <u>Manchester, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leisters Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rural Westminster, Md.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myer, Jr., Westminster Md. 21157</u>				25a. REC'D BY REGISTRAR <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



16778

## CERTIFICATE OF DEATH

16772

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>MAPLE AVE.</u>	
3 NAME OF DECEASED (Type or print) <u>GEORGE LANGDON GASSMAN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUNE 1, 1912</u>
9 AGE (In years last birthday) <u>55</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE - SALESMAN - DOOR TO DOOR</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>DOOR TO DOOR</u>		11 BIRTHPLACE (County & State, or foreign country) <u>AUGUSTA CO. VA.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>GEORGE LACKEY GASSMAN</u>	
14 MOTHER'S M maiden name <u>JULIA A. RUSSELL</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWII</u>	
16 SOCIAL SECURITY NO <u>218-32-1100</u>		17 INFORMANT <u>MRS. MILDRED B. GASSMAN</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE ANTERIOR MYOCARDIAL</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>INFARCTION</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>12/8</u> , 1967, to <u>12/12</u> , 1967, that (I) (we) last saw the deceased alive on <u>12/12 1967</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Brown Jr. MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>12/12/67</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/15/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARK'S CEMETERY</u>	23d. LOCATION (City or town) (County) (State) <u>SILVER RUN CARROLL MD</u>
24. FUNERAL DIRECTOR <u>J.S. Myer, Jr. WESTMINSTER, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 14 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER RURAL</b> c. LENGTH OF STAY IN 1b <b>1 1/2 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEADOWVIEW NURSING HOME ROUTE #1</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>303 OVERLOOK TERRACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>WILLIAM H.</b> First Middle Last 4. DATE OF DEATH <b>HARBAUGH DEC 31 1967</b> Month Day Year						5. SEX <b>MALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Ret.)</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>						11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Oscar Harbaugh</b>						14. MOTHER'S MAIDEN NAME <b>Rebecca Holtzman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> 16. SOCIAL SECURITY NO. <b>WWI 1918-19 218-10-7125</b>						17. INFORMANT <b>Bianche U. Harbaugh</b> Address <b>303 Overlook Tr. Westminister, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC HEART FAILURE</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DIS</b> DUE TO (c) <b>7 YEARS</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 1959</b> to <b>DEC 1967</b> , that (I) (we) last saw the deceased alive on <b>DEC 31 1967</b> , and that death occurred at <b>1:40 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Daniel I Welliver</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>DANIEL I WELLIVER</b>						22d. ADDRESS <b>WESTMINSTER MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-3-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memo Park</b>				23d. LOCATION (City, town or county) (State) <b>Sykesville, Md.</b>	
24. FUNERAL DIRECTOR <b>John E. Hoff</b> ADDRESS <b>Hampstead, Md.</b>						25a. REC'D BY REGISTRAR <b>SA 3 1968</b> 25b. REGISTRAR'S SIGNATURE <b>J. [Signature]</b>					

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and the limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from the study.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the conclusions drawn from the results. It also mentions the limitations of the study and the need for further research.

5. The fifth part of the report is a list of references. It includes a list of the books, articles, and other sources used in the study. It also includes a list of the people who have helped in the study.

Item 18 Film 396 1-9-67 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>37 Ridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GARNETTE L. HENDRICKSON</b>		4. DATE OF DEATH <b>December 20, 1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1896</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Ghent, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert C. Lilly</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>513-34-5449</b>	
17. INFORMANT <b>Dean W. Hendrickson</b>		Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X</b> DUE TO <b>Ruptured aortic aneurysm</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Atherosclerotic vascular disease</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/20, 1967</b> to <b>12/20, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/20, 1967</b> , and that death occurred at <b>11:20 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Harsney</b> M.D.		22b. ADDRESS <b>8 Anchor St Westminster, Md</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSNEY, M.D.</b>		22d. LOCATION (City, town or county) (State) <b>Bluefield RD, W. Va.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>12/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Monte Vista Park Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr., Westminster, Md. 21157</b>		25a. REC'D BY REGISTRAR <b>DEC 26 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove rotobon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16778

16775

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 mo 3 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3158 Remington Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <b>Anthony John Herbert</b>		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>1967</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-2-93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red.) <b>Railroad Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>74</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____
11 BIRTHPLACE (County & State or foreign country) <b>Minnesota</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Anthony Herbert, dec.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth dec.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1918</b>		16. SOCIAL SECURITY NO. <b>378-05-9684</b>	17 INFORMANT <b>Hospital records</b> Address _____
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOsclerotic Heart Disease</b> DUE TO (b) <b>Chronic Brain Syndrome</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-17</b> , 19 <b>67</b> , to <b>12-8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-8</b> , 19 <b>67</b> , and that death occurred at <b>10:30 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>Ramon P. Lopez</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12-8-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Mt. Vernon</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Burger Funeral Home</b>		ADDRESS <b>3631 Falls Rd Bk</b>	25a. REC'D BY REGISTRAR DATE <b>DEC 11 1967</b>
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## CERTIFICATE OF DEATH

16782

15776

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>C</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN lb <u>1 year 2 mos</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d STREET ADDRESS <u>449, N Elwood Ave</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>George Irwin Hugg</u>		4. DATE OF DEATH Month Day Year <u>December 31 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1881</u>
9 AGE (In years last birthday) <u>86</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Hugg</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Irwin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes 1902-1906</u>		16. SOCIAL SECURITY NO. <u>George Hugg, RD 5, Westminster, Md.</u>	
17. INFORMANT Address <u>George Hugg, RD 5, Westminster, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - chronic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m <u>pm 19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-17</u> , 19 <u>66</u> , to <u>Dec 31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec 30</u> 19 <u>67</u> , and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Joseph E. Bush M.D.</u>		22b. DATE SIGNED <u>12 31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>NAMPSTEAD Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/31/68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore Street</u>		25a. REC'D BY REGISTRAR <u>JA</u> 4 1968 DATE	





# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MB  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Carroll County General Hospital</i>		d. STREET ADDRESS <i>Mt Airy</i>	
3 NAME OF DECEASED (Type or print) <i>CORNA JOHNSON</i>		4 DATE OF DEATH Month <i>12</i> - Day <i>4</i> Year <i>1967</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>April 25, 1882</i>
9 AGE (In years last birthday) <i>85</i> yrs		IF UNDER 1 YEAR: Months <i>4</i> Days <i>19</i> Hours <i>17</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11 BIRTHPLACE (State or foreign country) <i>Tenn.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13 FATHER'S NAME <i>George Manis</i>		14 MOTHER'S MAIDEN NAME <i>Jane Lawson</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16 SOCIAL SECURITY NO <i>none</i>	
17 INFORMANT <i>McIsam Johnson</i>		Address <i>Mt Airy, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Failure</i> DUE TO (b) <i>Arterio-Sclerotic Heart Disease</i> DUE TO (c) <i>diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fall at Home</i>	
20c. TIME OF INJURY Month Day Year <i>8:00 PM 11-25-67</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Mt Airy Carroll Md</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>W. Glenn Speiker</i>		22. DATE SIGNED <i>12-4-67</i>	
EXAMINER'S NAME (Type) <i>W. GLENN SPEIKER</i>		23a. STREET CITY AND STATE OR COUNTY <i>135 S. Howard Westminster Md</i>	
23a. BURIAL, CREMATION, OR DISPOSITION (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12-7-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. John's</i>	23d. LOCATION (City or Town) (County) (State) <i>Elkton City, Md</i>
24. FUNERAL DIRECTOR <i>Arthur H. Haight</i>		25a. RECEIVED BY REGISTRAR <i>Highville, Md.</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		DEC 11 1967	



## CERTIFICATE OF DEATH

16784

15778

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>		d. STREET ADDRESS <u>RURAL, WESTMINSTER RD #5</u>	
3. NAME OF DECEASED (Type or print) <u>Paul Francis Johnson</u>		4. DATE OF DEATH <u>12 - 18 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 28 1904</u>
9. AGE (In years lost birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERICAL WORKER, OIL DISTRIBUTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO, MD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM P. JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>MAY SIXX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-01-9161</u>	
17. INFORMANT <u>Mrs Paul F. Johnson, address same</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis &amp; Myocardial Infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ABOUT 2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>54</u> , to <u>12/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> 19 <u>67</u> , and that death occurred at <u>5:45</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Julius Chapko</u>		22b. DATE SIGNED <u>12/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Julius Chapko</u>		22d. ADDRESS <u>254 W. Green Westminster, Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH</u>		23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER, MD</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers Jr., Westminster, Md</u>		25a. REC'D BY REGISTRAR <u>DATE DEC 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Michaela Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

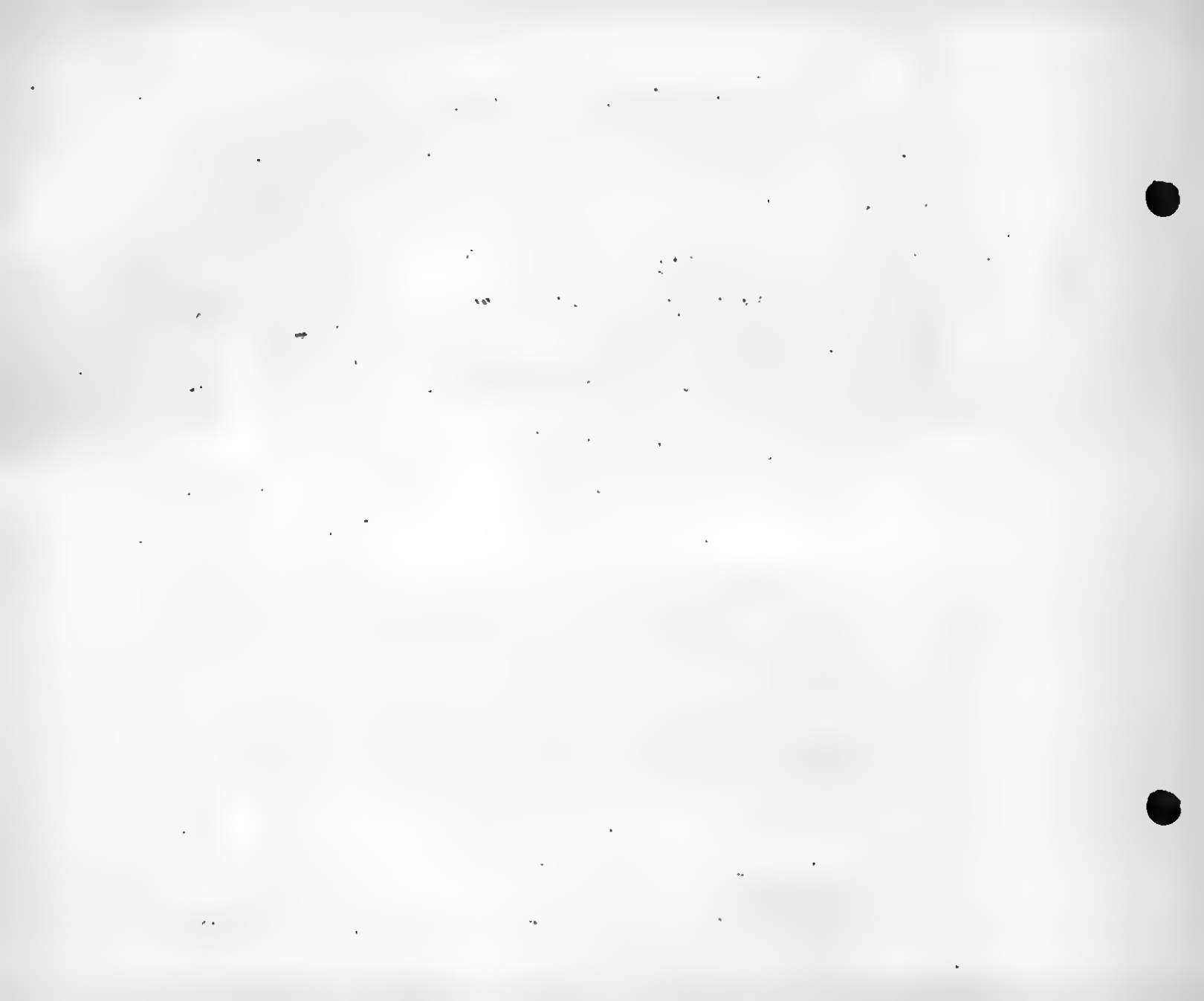


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 415 (4)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>SUSIE NMN. (Rose) Jones</i>			2a. DATE OF DEATH 12 Month 28 Day 67 Year			2b. HOUR 9 <sup>15</sup> P M			
3. SEX <i>Female</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>10-16-82</i>		6. AGE (In years lost birthday) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.			
10. CITY OR TOWN OF DEATH <i>Sykesville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Springfield State Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Sharpsburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>Patrick Henry Rose</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Blair</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>240-54-6893</i>		17. INFORMANT <i>Springfield Hosp. Records</i>		Address <i>Sykesville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>TERMINAL PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ARTERIO SCLEROTIC HEART DISEASE</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>CHRONIC BRAIN SYNDROME</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 67		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <i>6-25</i> , 19 <i>65</i> , to <i>12-28</i> , 19 <i>67</i> , that (X) (we) last saw the deceased alive on <i>12-28</i> , 19 <i>67</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Gracito V. Patricia</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>12-28-67</i>			
22d. PHYSICIAN'S NAME (Type) <i>Gracito V. Patricia</i>		22e. ADDRESS <i>Springfield State Hosp.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 1 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Towson Chapel Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Sharpsburg, Md.</i>			
24. FUNERAL DIRECTOR <i>John R. Watson Jr. Hagerstown Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JAN 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John R. Watson Jr.</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>(NMN)</b> Last <b>KAUFMAN</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>14</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-1905</b>
9. AGE (in years last birthday) <b>62</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Kaufman</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Weisblatt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unk.</b>	
17. INFORMANT <b>MRS. MILTON SAPPERSTEIN</b>		Address <b>3416 TRAINOR AVENUE</b> <b>Records, Springfield State Hospital #21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal bronchopneumonia</b> DUE TO (b) <b>Small bowel obstruction due to adhesions</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, other and unspecified.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-13-32</b> , 19__ to <b>12-14-67</b> , that (I) (we) last saw the deceased alive on <b>12-14-67</b> , and that death occurred at <b>6:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Anastasio M. Castiello</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Anastasio M. Castiello</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-15-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN RD.</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>

MEDICAL CERTIFICATE ON





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A 34 VR A15 (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> c. LENGTH OF STAY IN b. <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MIDDLEBURG</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u> d. STREET ADDRESS <u>MIDDLEBURG</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MAURICE WILLIAM LATE</u> First Middle Last						4. DATE OF DEATH <u>DEC 18 1967</u> Month Day Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 9 - 1896</u> Yrs. Months Days		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOP</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN LATE</u>						14. MOTHER'S MAIDEN NAME <u>ELIZABETH POWELL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>216-22-8490</u>					
17. INFORMANT <u>NETTIE LATE</u> Address <u>MIDDLEBURG MD</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 1 1 1 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Epithelial Cell carcinoma left neck</u> (c) <u>6 months.</u> INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 1967</u> to <u>Dec 18 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 17 1967</u> , and that death occurred at <u>3AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>J H Caricoff</u>						22b. DATE SIGNED <u>12/18/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>J H CARICOFF</u>						22d. ADDRESS <u>UNION BRIDGE MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>				23d. LOCATION (City, town or county) (State) <u>WOODSBORO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hertzler &amp; sons</u>						25a. REC'D BY REGISTRAR <u>DEC 21 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>William Judge</u>											



1 2 3



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15782

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>CARROLL</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN TB <b>DOA</b>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>		RURAL	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL CO. GENERAL HOSPITAL</b>		d STREET ADDRESS	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>KENNETH LEE LEMMON</b>		4 DATE OF DEATH Month <b>12</b> - Day <b>26</b> Year <b>1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MAY 28 - 1915</b>
9 AGE (In years last birthday) <b>52</b> yrs		FUND 1 YEAR Months Days FUND 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>JOHN LEMMON</b>		14 MOTHER'S MAIDEN NAME <b>ELEANORA BOWERS</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES W W II</b>		16 SOCIAL SECURITY NO <b>213-61-9254</b>	
17 INFORMANT <b>DE CHAUNCE LEMMON</b>		Address <b>UNION BRIDGE MD</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (G.C.)</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. GLENN SPEICHER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		23d. LOCATION (City or town) (County) (State) <b>NEW WINDSOR MD</b>	
24. FUNERAL DIRECTOR <b>D.D. Hartzler &amp; Sons Union Bridge</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 28 1967</b>	
25b. REGISTRAR'S SIGNATURE		22. DATE SIGNED <b>112-26-67</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16783

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u>		c. LENGTH OF STAY IN 1b <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Louiseville Road</u>		d. STREET ADDRESS <u>Cherry Hill Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Erle</u> Middle <u>J.</u> Last <u>Linthicum</u>		4 DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 8, 1899</u>
9. AGE (In years and birthday) <u>68</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co. Md.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>E. Gernott Linthicum</u>		14 MOTHER'S MAIDEN NAME <u>Gertrude Wronenburg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-18-3290</u>	
17 INFORMANT <u>Mrs. Virgie G. Linthicum</u>		Address <u>Reisterstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mins.</u> <u>17 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> , 19 <u>50</u> , to <u>Dec. 1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 17</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>12-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>59 Hanover Rd. Reisterstown, Md.</u>	
23a. BURIAL CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 4, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Finksburg, Md.</u>
24 FUNERAL DIRECTOR <u>J. F. Eline &amp; Sons</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 4</u> 19 <u>67</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

16730

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16784

1 PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>( )</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster (Finksburg Rd)</b>		c. LENGTH OF STAY IN 1b <b>Finksburg RD #2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 91 and intersection to Congaleum</b>		d. STREET ADDRESS <b>Schoolhouse Lane</b>	
3 NAME OF DECEASED (Type or print) <b>ROBERT</b> <b>RICHARD</b> <b>Earl</b> <b>MANN</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1947</b>
9 AGE (in years lost birthday) <b>20</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool maker apprentice</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carroll Co., Maryland</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12 C. T. ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Earl F. Mann</b>		14. MOTHER'S MAIDEN NAME <b>Doris Smith</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>( )</b>		16 SOCIAL SECURITY NO. <b>217-50-1965</b>	
17 INFORMANT <b>Earl F. Mann</b>		Address <b>same</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. <b>Asphyxia</b> <b>823.4</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO (b) <b>in his car</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Subject plunged down an embankment into Patapsco River</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>in his car</b> <b>Subject plunged down an embankment into Patapsco River</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:45</b> AM <b>12 10 19 67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Road-Water</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <b>Westminster Carroll Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>December 11, 1967</b>	
ACTUAL SIGNATURE <b>Edward F. Wilson</b> EXAMINER'S NAME (Type) <b>Edward F. Wilson, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Finksburg, Md.</b>	
24 FUNERAL DIRECTOR <b>J. S. Myers, Jr., Westminster, Md.</b>		25a. REC'D BY REG. STRAR <b>DEC 14 1967</b>	
25b. REG. STRAR'S SIGNATURE <b>J. Charles Jones</b>			





## CERTIFICATE OF DEATH

16791

16785

1 PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 MON</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE, CITY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRINGFIELD STATE HOSPITAL</b>		d. STREET ADDRESS <b>1006-C WOODSON RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>PERNNELL</b> Last <b>MILNOR</b>		4 DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>67</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-83</b>
9 AGE (In years) <b>84</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State or foreign country) <b>DELAWARE</b>		12 CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>WILLIAM, THURSBY</b>		14. MOTHER'S MAIDEN NAME <b>EDITH BIDDLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>213-50-2714</b>	
17. INFORMANT <b>SPRINGFIELD HOSP, RECORDS</b>		Address <b>SYKESVILLE Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>570.2</b> IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY ARTERY EMPOLISM.</b> DUE TO (b) <b>MESENTERIC THROMBOSIS WITH NECROSIS TRANSVERSE COLON.</b> DUE TO (c) <b>COLON.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>CBS, ASSOCIATED WITH CEREBRAL ARTERIOSCLEROSIS WITH PSY. REAC.</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-16-67</b> , 19__, to <b>12-17-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>12-17-67</b> , 19__, and that death occurred at <b>2.30M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Naci N. Bilykunas</i>		22b. DATE SIGNED <b>12/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NACI N. BILYKUNAS</b>		22d. ADDRESS <b>SPRINGFIELD STATE HOSPITAL, SYKESVILLE, MARYLAND 21784</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1967</b>	
ADDRESS <b>4905 York Road Baltimore Md. 21212</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

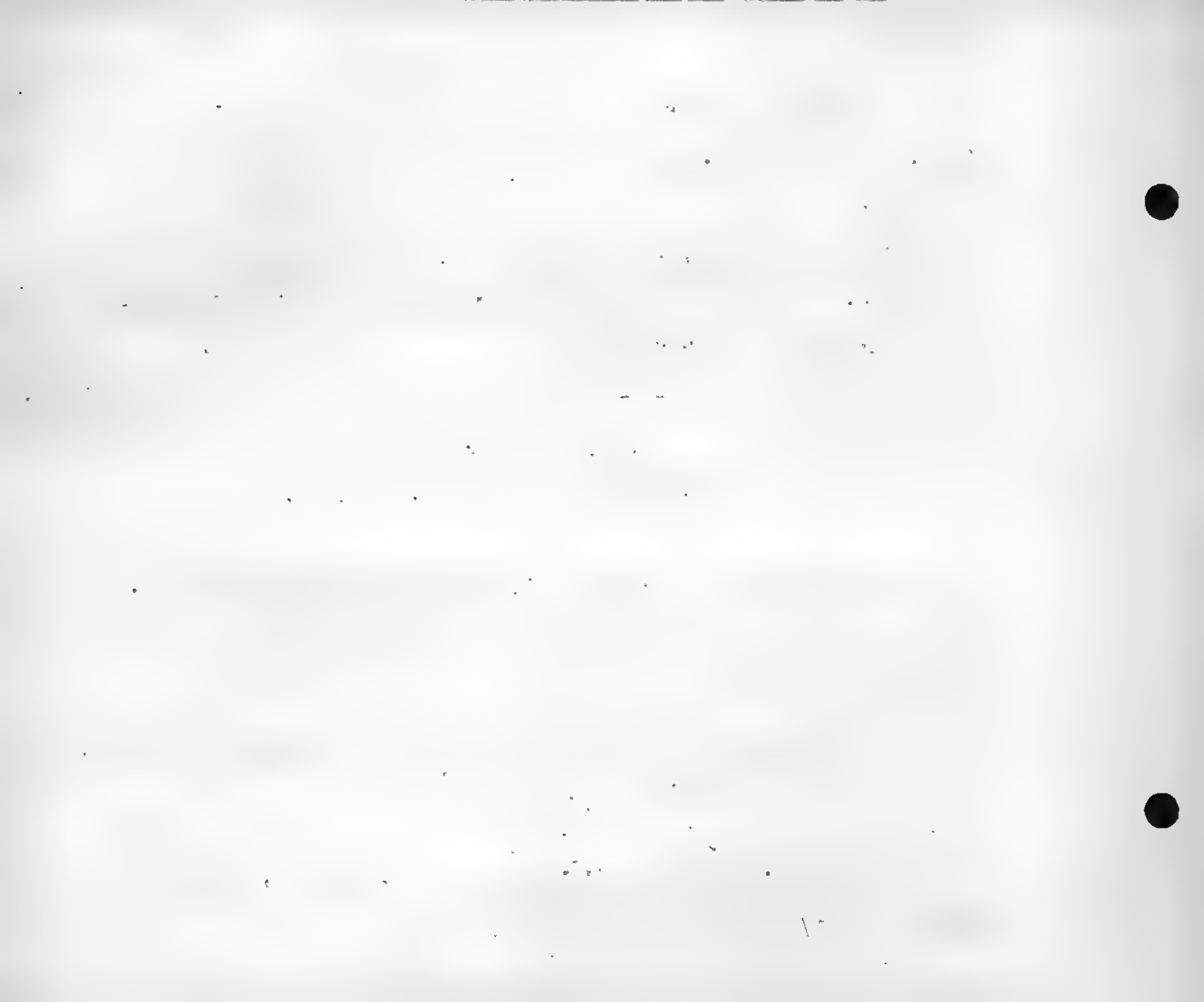


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me (Type or print) in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1-68

16792										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 -														
CERTIFICATE OF DEATH										10786														
1 DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
Edna Belle Murray										Month 12 Day 29 Year 67					7:30 am									
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.											
female		white		1/6/93			74 YRS			MONTHS			DAYS											
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Maryland					USA										Carroll Md.									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
Sykesville					Springfield State Hospital					housewife														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY, APTS?									
Md.										Baltimore					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET AND NUMBER					14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
3606 Monteray Road					First Middle Last					First Middle Last														
Edward Seidenstricker					Ellen Nizer																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
no					212-32-3874B					Springfield Hospital records, Sykesville, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Congestive heart failure															days									
4221 DUE TO, OR AS A CONSEQUENCE OF																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																								
(b) Arteriosclerotic cardiovascular disease															years									
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease with neurotic reaction.																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No City or Town County State									
22a. I certify that (X) (this hospital) attended the deceased from 12/19/1967, to 12/29/1967, that (X) (we) last saw the deceased alive on 12/29/1967, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Naci N. Buyukunsal, M.D.															12/29/67									
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																			
					Springfield State Hospital Sykesville, Maryland																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
BURIAL					1/2/68					Moreland Mem. Park					Balto. Co.									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Mitchell-Niedefeld Home-6500 York Rd-21212															JAN 5 1968									



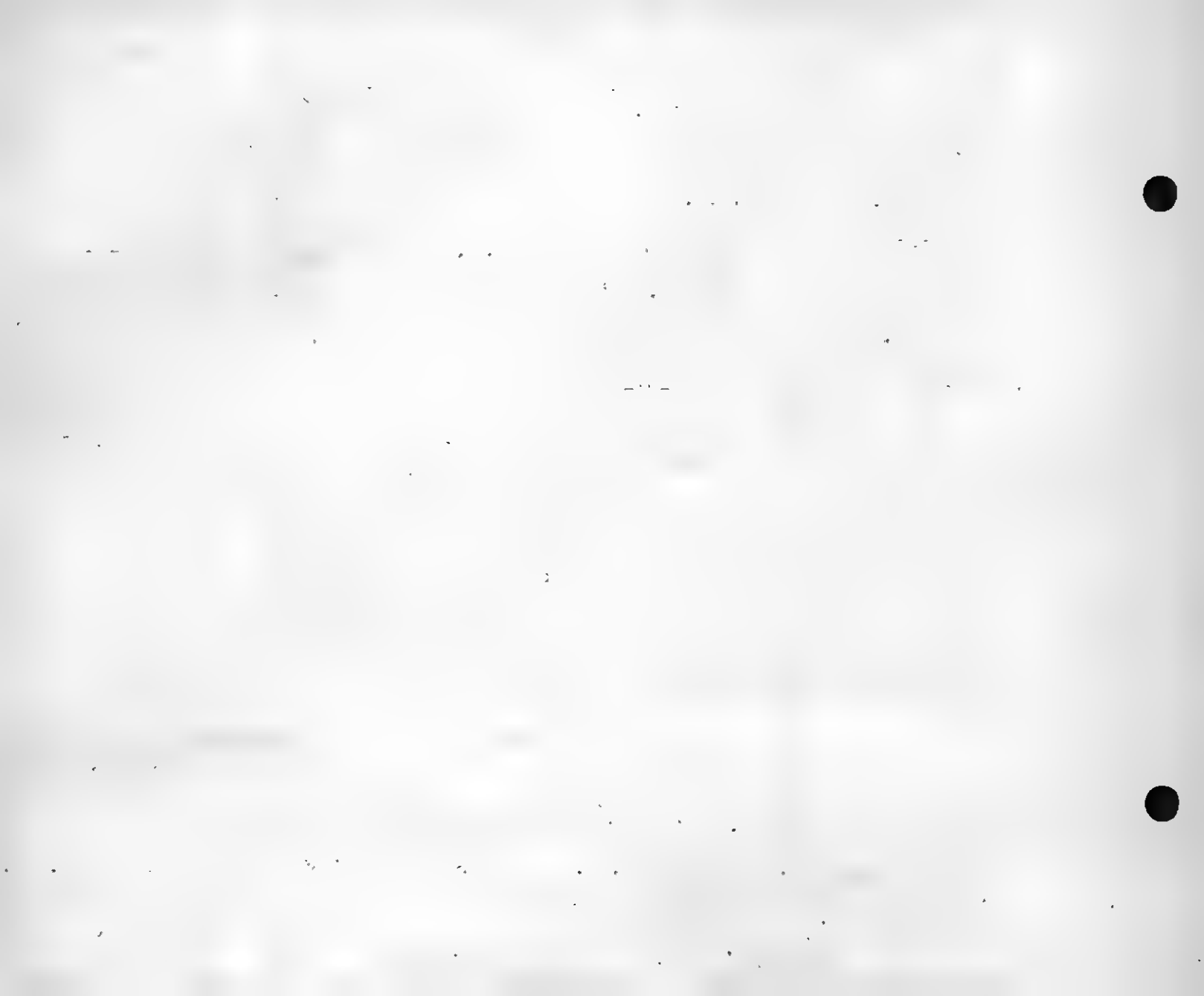
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First FRANK		Middle THOMPSON		Last NASUTA (MILLER)		2a DATE OF DEATH 12 Month 14 Day 67 Year		2b. HOUR 8 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 06/15/03		6. AGE (In years lost birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.					
10 CITY OR TOWN OF DEATH SYKESVILLE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRINGFIELD STATE HOSP.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Odd Jobs		12b KIND OF BUSINESS OR INDUSTRY ---			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Balto. City		13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER unknown			
14 FATHER'S NAME First THOMAS		Middle NASUTA		Last NASUTA		15 MOTHER'S MAIDEN NAME First ELIZABETH		Middle CIERZONAK (GANZMILLER)		Last GANZMILLER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		(If yes give year or dates of service) 1919		16b. SOCIAL SECURITY NO. 219-03-1453		17 INFORMANT Hospital Records Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Schizophrenic reaction, catatonic type											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 01/20/40, 19__, to 12/14/67, 19__, that (I) (we) lost saw the deceased alive on 12/14/67, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Joseph S. Weinstock M.D.		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/14/67	
22d PHYSICIAN'S NAME (Type) Joseph S. Weinstock, M. D.		22e. ADDRESS Springfield State Hospital, Sykes., Md.									
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-20-67		23c. NAME OF CEMETERY OR CREMATORY CREST LAWN CEM.		23d. LOCATION (City or Town) BALTO, MD.		(County)		(State)	
24. FUNERAL DIRECTOR Hartley Miller		ADDRESS 2334 Jefferson St.		25a. REC'D BY REGISTRAR DATE DEC 22 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16794

16788

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Alleghaney</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN lb <b>3y1m.1d</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clifton Harrison Nixon</b>		4. DATE OF DEATH Month Day Year <b>12 4 19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/13</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ellwood Nixon</b>		14. MOTHER'S MAIDEN NAME <b>Clara Twigg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4-41x</b> DUE TO <b>Broncho Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional Psychotic Reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>11/2/64</b> , 19 <b>67</b> , to <b>12/17</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>12/17</b> , 19 <b>67</b> , and that death occurred at <b>10:30 PM</b> , from causes and on the date stated above			
22a. SIGNATURE <b>H. E. Conner, Jr.</b>		22b. DATE SIGNED <b>12/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. E. Conner, Jr., M. D.</b>		22d. ADDRESS <b>Springfield State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>12/8/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>U. of M. Anatomy Board</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Howell Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Pikeville 8-114</b>	
25b. REGISTRAR'S SIGNATURE <b>J. F. M.</b>		DATE <b>DEC 12 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.





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VR A15 (4)  
25M 1/67

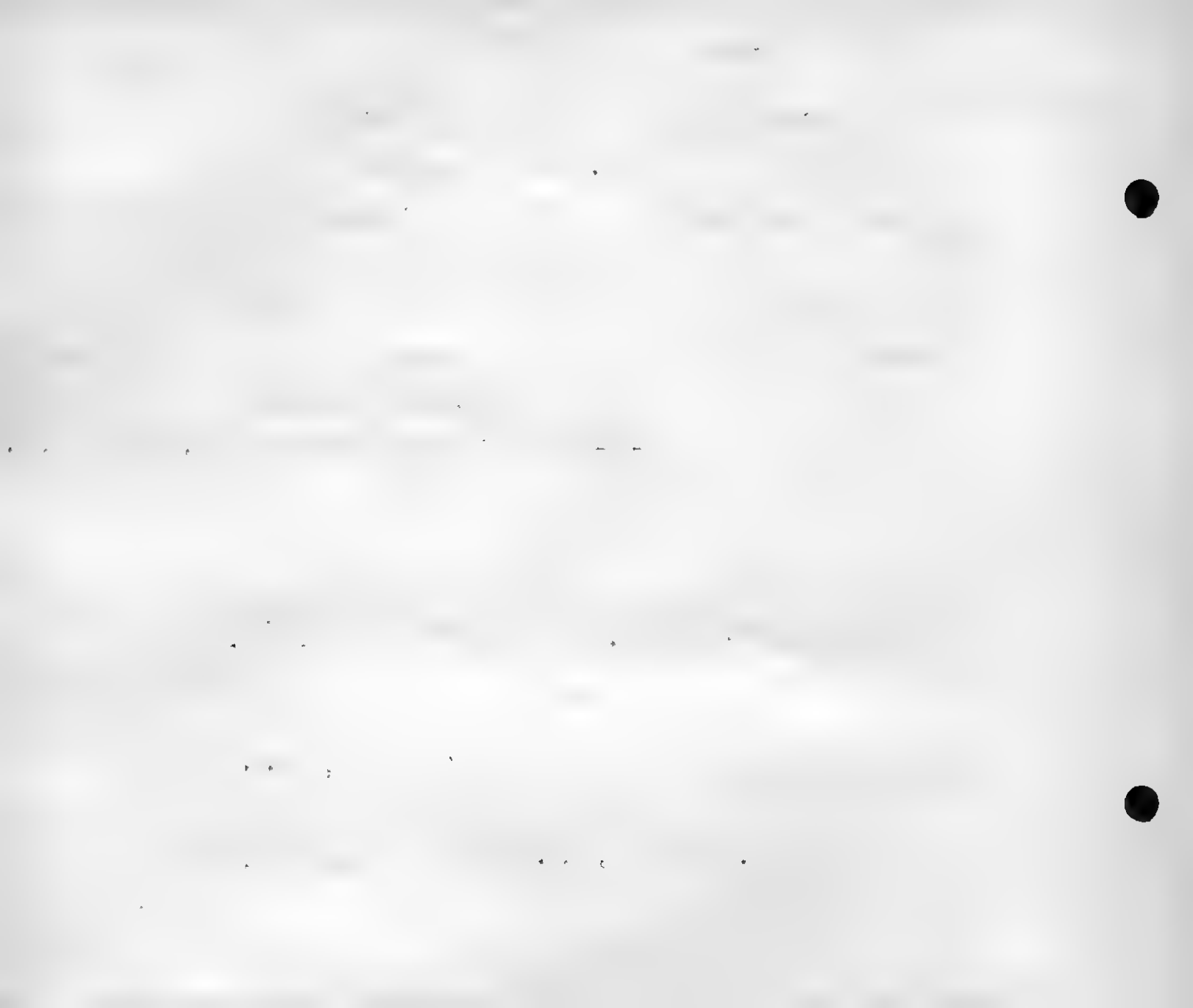
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16795

CERTIFICATE OF DEATH

16789

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Sykesville</b>		c. LENGTH OF STAY IN It <b>8mo. 9days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>5111 Plymouth Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Fedis</b> Last <b>Ortel</b>			4. DATE OF DEATH Month <b>12</b> Day <b>12</b> Year <b>19 67</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/81</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>		11. BIRTHPLACE (County & State or foreign country) <b>Maryland Baltimore</b>	
13. FATHER'S NAME <b>Nicholas Ortel</b>			14. MOTHER'S MAIDEN NAME <b>E. Fleisidis Straup</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>554-01-9060</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO <b>490x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH Days _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction. Recent subdural hematoma, left.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF DEATH Month, Day, Year Hour <b>19</b> m. <b>pm</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/3/</b> , 19 <b>67</b> , to <b>12/12/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/12/</b> , 19 <b>67</b> , and that death occurred at <b>10:30</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Naci N. Buyukunsal</i> M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>12-15-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Luth Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>	
24. FUNERAL DIRECTOR <i>Kassabian Funeral Home</i>		ADDRESS <b>7401 Belair</b>		25a. REC'D BY REGISTRAR <b>DEC 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Juan Carlos J...</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the spaces provided, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16796

10790

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco</u> d. STREET ADDRESS <u>Old quarter Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elmer</u> First <u>R.</u> Middle <u>Peregoy</u> Last <b>4. DATE OF DEATH</b> <u>December 15,</u> 19 <u>67</u> Month Day Year		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 16, 1904</u> <b>9. AGE</b> (In years last birthday) <u>63</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bookkeeper for Norman W. Meekins Co.</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>W. Meekins Co.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore City</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>		<b>13. FATHER'S NAME</b> <u>Emory Peregoy</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Georgiana Klausman</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>212-01-7467</u> <b>17. INFORMANT</b> <u>Mrs. Marion Peregoy</u> Address <u>Upperco, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1 Atherosclerotic Heart Disease</u> 42.50 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } b) <u>2 Co pulmonale</u> DUE TO c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>12/13/67</u> Hour a.m. <u>19</u> p.m. <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/13</u> <u>1967</u> <b>to</b> <u>12/15</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> <u>1967</u> and that death occurred at <u>4:25</u> P.M. from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>John S. Harshey</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN S. HARSHEY, M.D.</u>		<b>22b. DATE SIGNED</b> <u>12/15/67</u> <b>22d. ADDRESS</b> <u>8 Archer St. Westminster, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>12/18/67</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Reisterstown Methodist</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Reisterstown, Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Eline &amp; Sons</u> ADDRESS <u>Reisterstown, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminister</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll County General</b>		d. STREET ADDRESS <b>6824 Dunbar Road</b>	
3 NAME OF DECEASED (Type or print) <b>ROBERT EDWARD PIERCE</b>		4 DATE OF DEATH Month <b>12</b> - Day <b>20</b> - Year <b>1967</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>caucasian</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4 Dec. 1935</b>
9 AGE (in years last birthday) <b>32</b> yrs		10 FUNDING YEAR Months Days Hours Min.	
10a US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rodman</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Steel Erection</b>	
11 BIRTHPLACE (State or foreign country) <b>Wash. Co., Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Robert S. Pierce</b>		14 MOTHER'S MAIDEN NAME <b>Mary Frances Trent</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-42-8715</b>	
17. INFORMANT <b>Marie Henegar Pierce (Wife)</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>8124</b> IMMEDIATE CAUSE (a) <b>Fractured Skull &amp; neck</b> DUE TO (b) <b>&amp; multiple injuries</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Struck by car</b>	
20c TIME OF INJURY Month, Day, Year <b>7:45 pm 12-20 1967</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>U.S. 140</b>		20f (If city or town) County (State) <b>Westminister Carroll Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William Speiker</b>		22. DATE SIGNED <b>12-20-67</b>	
EXAMINER'S NAME (Type) <b>William Speiker</b>		23a REC'D BY REGISTRAR <b>James H. Stumacher</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Rem and Burial</b>		23b DATE THEREOF <b>12-21-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Old Glade Cem.</b>		23d LOCATION (city or town) County (State) <b>Glade Spring Virginia</b>	
24 FUNERAL DIRECTOR <b>J. Buckley</b>		25b REGISTRAR'S SIGNATURE <b>James H. Stumacher</b>	
25a ADDRESS <b>Henderson Funeral Chapel ABINGDON, VIRGINIA.</b>		DATE <b>DEC 28 1967</b>	



## CERTIFICATE OF DEATH

16798

16798

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>2 HOURS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL CO GENERAL HOSPITAL</b>		e. STREET ADDRESS <b>RURAL</b>	
3. NAME OF DECEASED (Type or print) <b>LEROY (NONE) POOLE</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. PLACE OF BIRTH <b>D.C.</b>
9. AGE (In years last birthday) yrs <b>62</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>	
12. DATE OF BIRTH <b>SEPT 27-1905</b>		13. CITIZENSHIP OF WHAT COUNTRY? <b>U.S.</b>	
14. FATHER'S NAME <b>GEORGE POOLE</b>		15. MOTHER'S MAIDEN NAME <b>ELIZABETH (UNKNOWN)</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO NO</b>		17. SOCIAL SECURITY NO. <b>NONE</b>	
18. INFORMANT <b>H. PAUL HULL, NEW WINDSOR MD</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>231X</b> DUE TO <b>Cerebral Vascular Accident</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <b>1 hour</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/11</b> , 19 <b>67</b> , to <b>12/11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/11</b> , 19 <b>67</b> , and that death occurred at <b>6:07</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>JOHN S. HARSNEY</b> M.D.		22b. DATE SIGNED <b>12/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSNEY, M.D.</b>		22d. ADDRESS <b>8 Anson St. Westminster, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>COUNTY HOME</b>	23d. LOCATION (City or Town) (County) (State) <b>CARROLL COUNTY MD</b>
24. FUNERAL DIRECTOR <b>DD HARTZLER &amp; SONS</b>		25a. REC'D BY REGISTRAR <b>DEC 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16799

16793

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 4mos. 12dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>14 N. Gay St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>GROVER</b> Middle <b>CLEVELAND</b> Last <b>RENN</b>				4 DATE OF DEATH Month <b>DECEMBER</b> Day <b>9</b> Year <b>1967</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-11-1893</b>		9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Mins. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. Renn</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hawkins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>229-16-0460A</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Laennec's cirrhosis</b>							INTERVA. BETWEEN ONSET AND DEATH <b>Years</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>0022</b>							(b) <b>Arteriosclerotic cardiovascular disease</b> <b>Years</b>
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with alcohol intoxication, without qualifying phrase</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>7-27-65</b> , 19 <b>65</b> , to <b>12-9-67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12-9-67</b> , 19 <b>67</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Gracito V. Patricio M.D.</b>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gracito V. Patricio, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-13-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedom Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Sykesville Md.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>				25a. REC'D BY REGISTRAR <b>Sykesville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

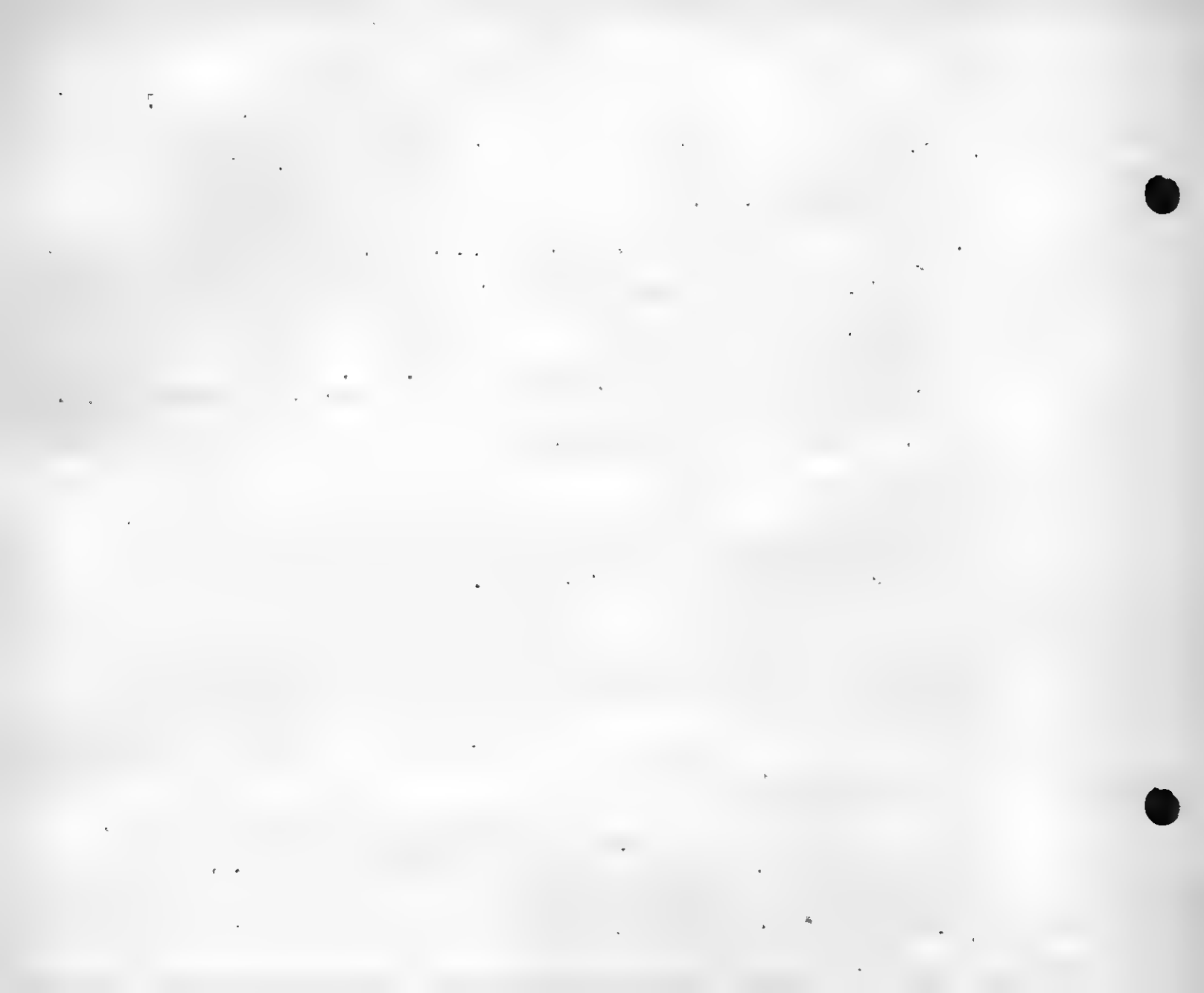


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

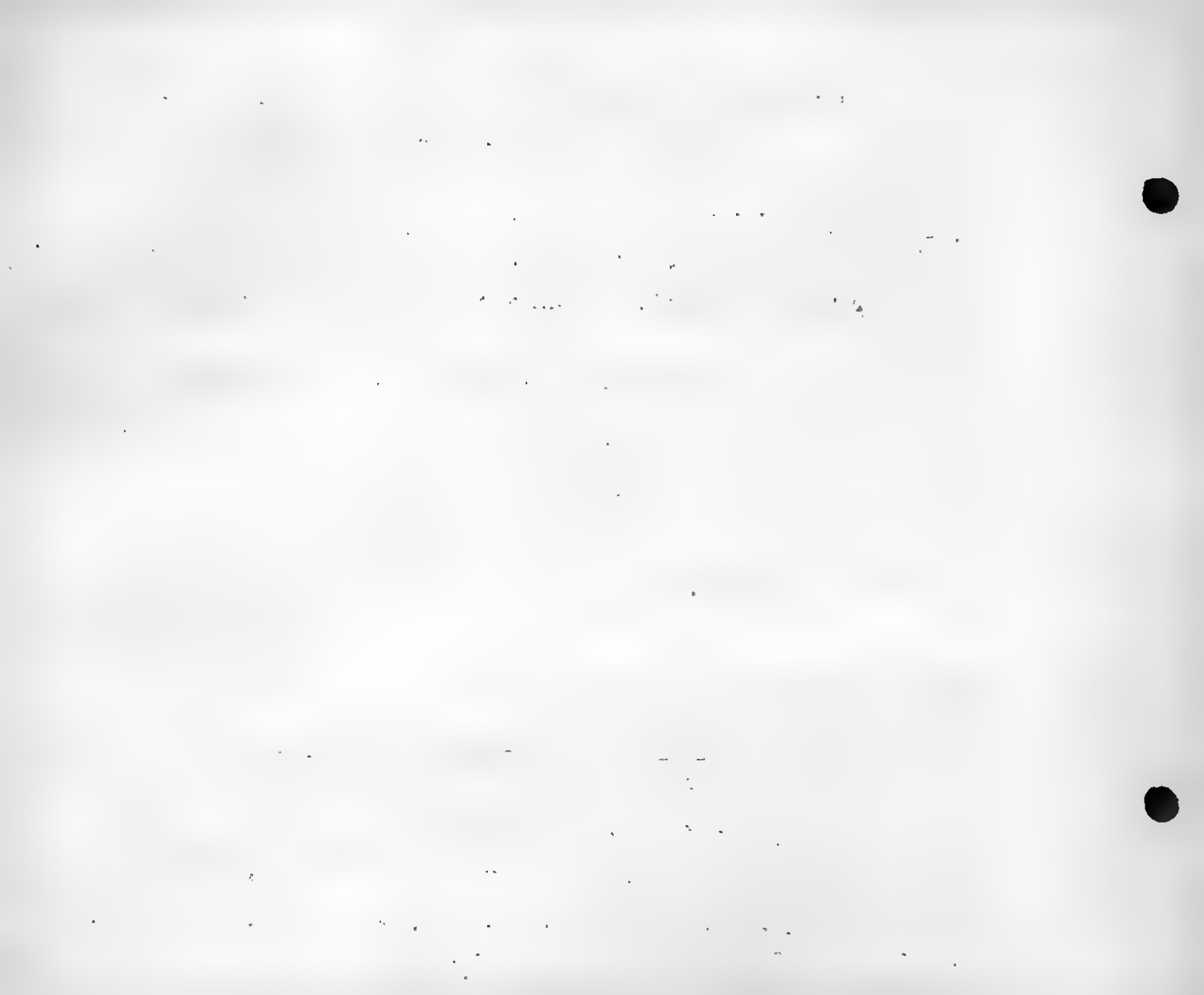
VR 1515  
30M REV. 1/76

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>Ivy</b>			First <b>None</b> Middle <b>Rizer</b> Last			2a. DATE OF DEATH Month <b>12</b> Day <b>21</b> Year <b>67</b>		2b. HOUR <b>2:15</b> <sup>am</sup> <sub>pm</sub>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>02-19-1902</b>		6. AGE (In years last birthday) <b>65</b> YRS		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Erostburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME <b>Alfred</b>			First <b>None</b> Middle <b>Rizer</b> Last			15. MOTHER'S MAIDEN NAME <b>Lucy</b>			First <b>Pape</b> Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>123-03-8209T</b>		17. INFORMANT <b>Med. Rec.</b>			Address <b>Springfield Hospital, Sykesville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>471X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Catatonic type.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (A) (this hospital) attended the deceased from <b>1-26-45</b> , 19____, to <b>12-20</b> , 19____, that (X) (we) lost saw the deceased alive on <b>12-20-67</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <b>Renato R. Espina, M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-20-67</b>		
22d. PHYSICIAN'S NAME (Type) <b>Renato R. Espina</b>						22e. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MARYLAND</b>				
24. FUNERAL DIRECTOR <b>Gary Drachy</b>		Address <b>Hayes - Lawrence Funeral Home</b> <b>60 W. Main St. Frostburg Md.</b>				25a. RECEIVED BY REGISTRAR <b>DEC 27 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. [Signature]</b>		



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/08



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/68

16802												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
1												CERTIFICATE OF DEATH												6796											
1 PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Hagerstown</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>						c. LENGTH OF STAY IN lb						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21220</u>																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hoodlone Estates</u>						d. STREET ADDRESS <u>19 Cockpit St.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3 NAME OF DECEASED (Type or print) First <u>August</u> B Middle <u>Schramm</u> Last <u>Schramm</u>						4 DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1967</u>																													
5 SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 24, 1878</u>		9 AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY				11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>																							
13. FATHER'S NAME <u>William Schramm</u>						14. MOTHER'S MAIDEN NAME <u>Mary Kern</u>																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-12-6425</u>				17. INFORMANT Address <u>Mr. H. Kenneth Schramm, 1101 St. Paul St.</u>																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, } (b) <u>Ch. Myocarditis</u> (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																											
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1st</u> , 19 <u>67</u> , to <u>Dec 29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Dec 15</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above.																																			
22a. SIGNATURE <u>H. H. Martin M.D.</u>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Dec 29-67</u>																											
22c. PHYSICIAN'S NAME (Type) <u>H. H. MARTIN M.D.</u>						22d. ADDRESS <u>Westminster Md.</u>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/2/68.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>																									
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						ADDRESS		25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Ruck</u>																									



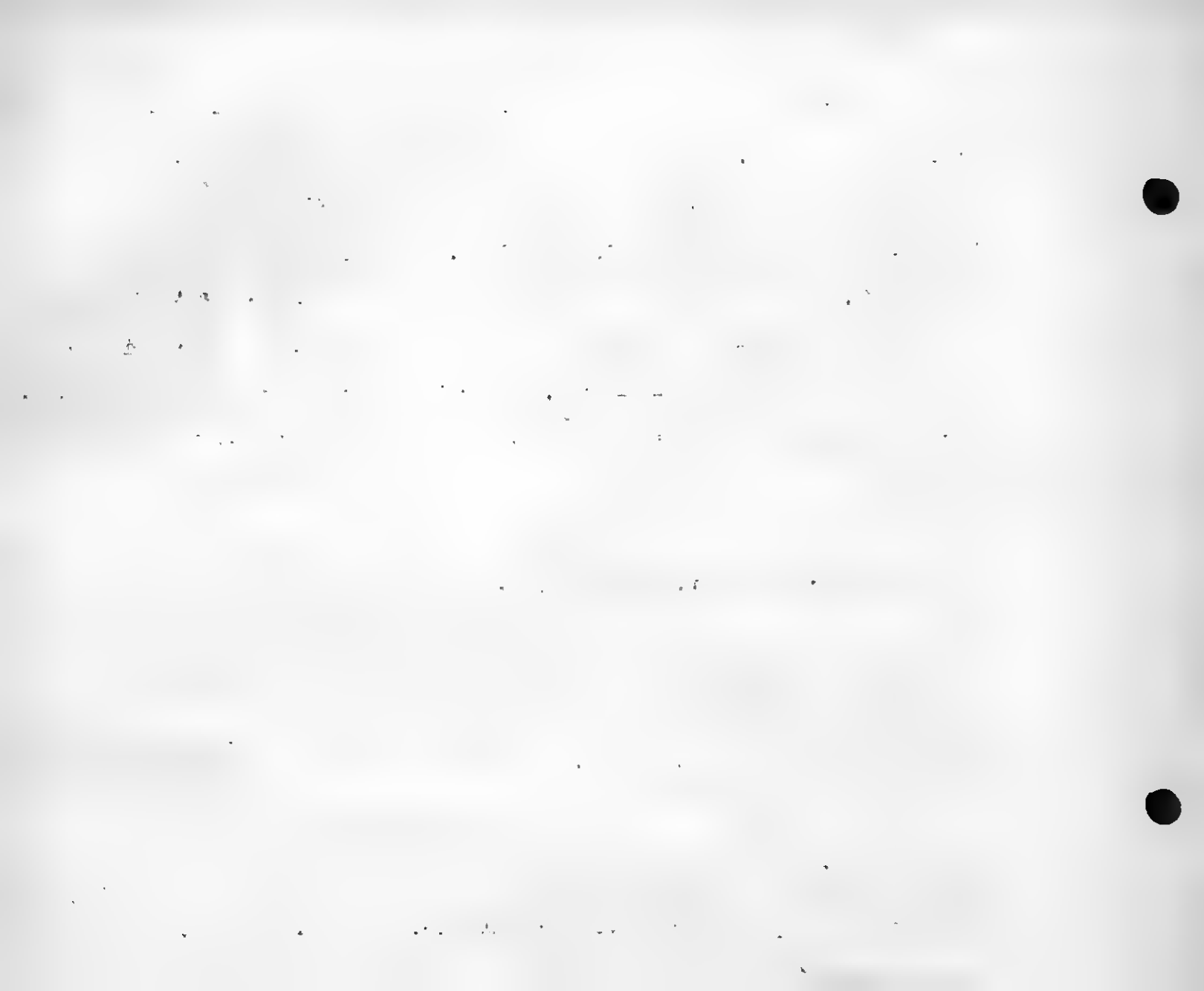


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (10)  
30M REV. 7-68

<div>16803</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>16797</div>												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Sarah			--			Serio			Month 12 Day 29 Year 67 6:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
female		white		7/26/89			78 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Italy		Italy					Carroll Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville			Springfield State Hosp.			housework						
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.						Baltimore				233 N. Pearl Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Jack -- Serio			Concetta Lamartana			XX						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address						
no			216-56-4765J			Springfield Hospital records, Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Cerebral vascular disease</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
<u>Schizophrenic reaction, paranoid type.</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>8/23/1939</u> , to <u>12/29/1967</u> , that <del>he</del> (we) last saw the deceased alive on <u>12/29/1967</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Charles V. Patrino</u> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>12-29-67</u>				
22d. PHYSICIAN'S NAME (Type) <u>GRACIO V. PATRINO</u>						22e. ADDRESS <u>Springfield State Hosp.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		Jan. 2 1968		New Cathedral Cem.		Baltimore Md.						
24. FUNERAL DIRECTOR <u>Frank J. Della Nore</u> ADDRESS <u>322 South High St.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
						DATE JAN 2 1968						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7(61)  
4/18/67

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL CO.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RT#6</u>	
c. LENGTH OF STAY in lb <u>3 1/2 DAYS</u>		d. STREET ADDRESS <u>WASHINGTON ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER</u> <u>MABEL</u> <u>SHIPLEY</u>		4. DATE OF DEATH Month Day Year <u>12</u> <u>5</u> <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 30, 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT WILSON</u>		14. MOTHER'S MAIDEN NAME <u>CONDON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>GEORGE C. SHIPLEY, WESTMINSTER, RT#6, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> (c) <u>CARDIOVASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> , 19 <u>67</u> to <u>12/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Fiocco, Jr.</u> M.D.		22b. DATE SIGNED <u>12/5/67</u>	
22c. PHYSICIAN'S NAME <u>VINCENT J. FIOCCO, JR.</u>		22d. ADDRESS <u>ANCHOR ST. WESTMINSTER, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEM.</u>		23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster, Md. 21157</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16805

16791

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3mo. 26days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		d. STREET ADDRESS <b>Route #7</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>M.</b> Middle <b>Marie</b> Last <b>Shoemaker</b>		4. DATE OF DEATH Month <b>12</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01/12/1900</b>
9. AGE (In years last birthday) yrs <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William P. Eyler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>216-22-2069</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>4201 Coronary thrombosis</b> DUE TO (b) <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, chronic undifferentiated type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/11/1967</b> , to <b>12/7/1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/7/1967</b> , and that death occurred at <b>1:50 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Renato R. Espina, M.D.</b>		22b. DATE SIGNED <b>12/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 11, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles J. Jorg</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Jorg</b>		DATE <b>DEC 11 1967</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
16806									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>			c. LENGTH OF STAY IN 1b <b>17y. 4m. 4d.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					d. STREET ADDRESS <b>Oaklee Village</b>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Alma</b>			First Middle Last <b>-- Small</b>		4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>1967</b>				
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/1/88</b>		9. AGE (in years last birthday) yrs. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Purdue</b>					14. MOTHER'S MAIDEN NAME <b>Amanda Bates</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>220-54-6278</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Pneumonia Right Lower Lobe</b> DUE TO (b) <b>440X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional Psychotic Reaction.</b>									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> m. <b>12-8-67</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/4/1950</b> , to <b>12-8-1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12-8-1967</b> , and that death occurred at <b>7:49 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Ramon P. Lopez</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-8-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>RAMON. P. LOPEZ</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove</b>			23d. LOCATION (City or Town) (County) (State) <b>Boonville Ind.</b>		
24. FUNERAL DIRECTOR <b>Harry W. Wright</b>					ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

MEDICAL CERTIFICATION





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Edward SMITH</b>		4. DATE OF DEATH <b>December 3, 1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-1-87</b>
9. AGE (In years last birthday) <b>80</b>		10. F UNDER 1 YEAR <b>3</b> F UNDER 24 HRS <b>1967</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer -retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Smith - dec.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jones - dec.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>214-34-2285</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Generalized Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Hip Fracture Rt</b> DUE TO <b>Chronic Brain Syndrome</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell at Home</b>		20b. TIME OF INJURY Month, Day, Year <b>Nov 17 1967</b>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <b>at work</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Home</b>	
20e. CITY OR TOWN <b>Frederick</b> (State) <b>Md</b>		20f. <b>Frederick</b>	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> M.D.		22. DATE SIGNED <b>12-3-67</b>	
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-6-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>		23d. LOCATION (City or town, (County) (State) <b>Frederick Md</b>	
24. FUNERAL DIRECTOR <b>Charles Hicks III</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
1086  
1080  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll Co. General Hospt.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>27 E. Main St.</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Herbert M. Snyder</b> First Middle Last		4. DATE OF DEATH <b>12 29 1967</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1911</b> 9. AGE (In years last birthday) <b>56</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co. Md.</b>
13. FATHER'S NAME <b>Cecil A. Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Dessie Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-01-4685</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411x BRONCHOPNEUMONIA, BILATERAL, EXTENSIVE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>LAENNEC'S CIRRHOSIS, FLORID</b>		17. INFORMANT <b>Mrs. Myrtle C. Snyder</b> Address <b>27 E. Main St. Westminster, Md.</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/28, 1967</b> to <b>12/29, 1967</b> , that (I) (we) last saw the deceased alive on <b>12/29, 1967</b> , and that death occurred at <b>12:22 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Vincent J. Krowc Jr.</b> M.D.		22b. DATE SIGNED <b>12/29/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 1, 1968</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hampstead, Md. 21074</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tipton - Eline Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1968</b> 25b. REC'D BY STATE JUDGE <b>Richard Judge</b>	



## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>26 yrs, 10 mos, 20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>Tritt</b> Last <b>Snyder</b>		4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-6-00</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>5</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel S. Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Katie B. Stitzel</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-48-8214-T</b>	
17. INFORMANT <b>records</b>		Address <b>Sykesville, Springfield State Hospital/Maryland</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Large adenocarcinoma of the stomach</b> DUE TO (b) <b>Extreme emaciation</b> DUE TO (c) <b>months or weeks</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Mental deficiency (familial or hereditary), severe</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 15, 19 41</b> to <b>December 5, 19 67</b> , that (I) (we) last saw the deceased alive on <b>December 5, 19 67</b> , and that death occurred at <b>10: A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Irfan Esendal, Irfan Esendal M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Irfan Esendal, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1229/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery near Hagerstown</b>	23d. LOCATION (City or Town) (County) (State) <b>Wash Co Md</b>
24. ADDRESS OF FUNERAL DIRECTOR <b>Hagerstown Md</b>		25a. REC'D BY REGISTRAR <b>Andrew K. Coffman Funeral Home Inc</b>	
25b. REGISTRAR'S SIGNATURE <b>DEC 11 1967</b>		25c. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

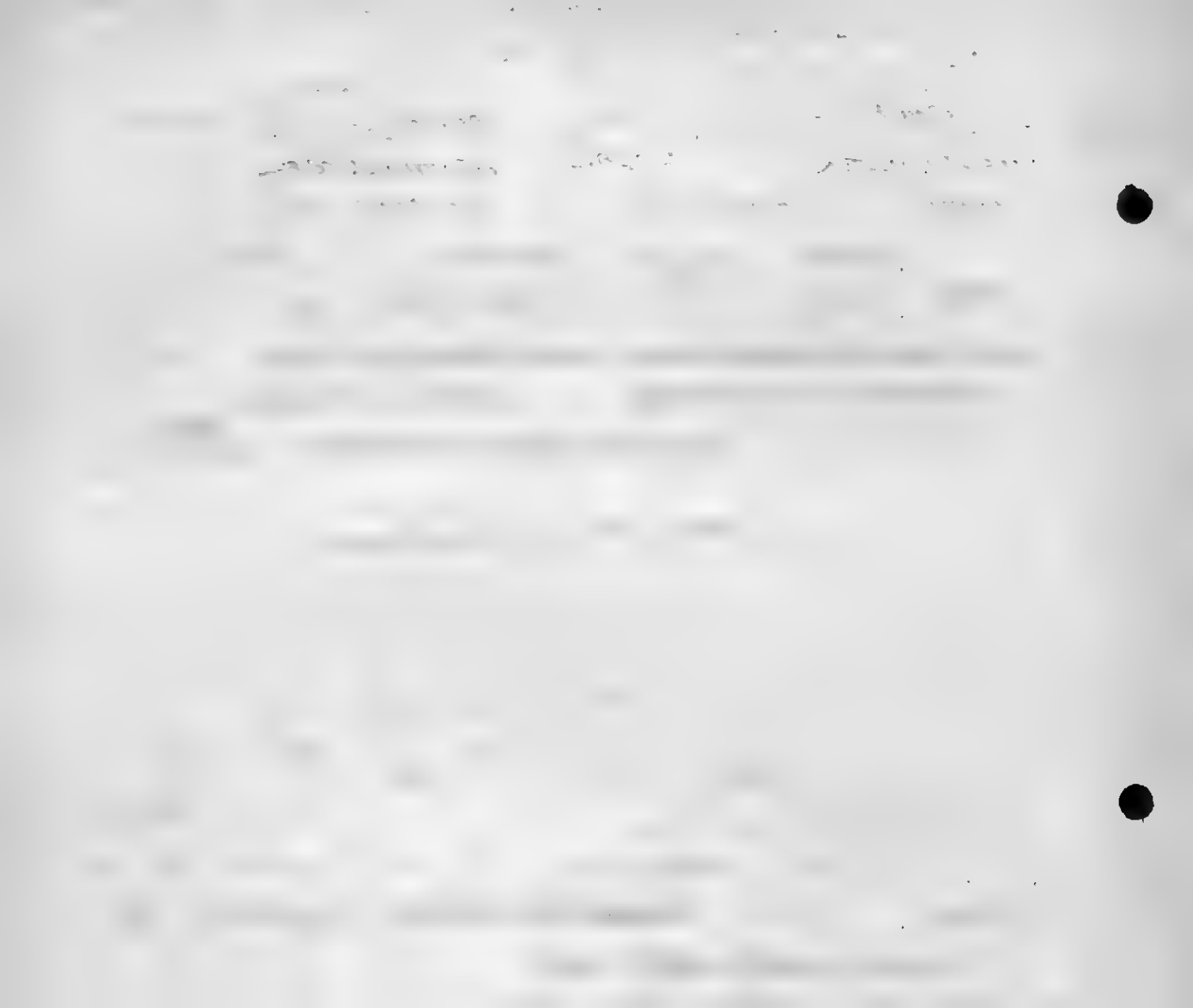
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4-10 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>						c. LENGTH OF STAY IN 1b <u>27 DAYS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>						e. STREET ADDRESS <u>64 BOND ST.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE VIRGINIA SPRINKLE</u>						4. DATE OF DEATH Month Day Year <u>DEC. 18 1967</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19, 1896</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE &amp; OPERATOR SEWING FACTORY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BAEDERICK CO MD.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>GEORGE W. MUMFORD</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE R. EYLER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>214-16-1222-A</u>					
17. INFORMANT <u>MR. GEO. H. SPRINKLE</u>						Address <u>SAME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>atherosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> <u>1967</u> to <u>12/18</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> <u>1967</u> , and that death occurred at <u>2:30</u> <u>P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>John S. Harshey</u> M.D.						22b. DATE SIGNED <u>12/18/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>						22d. ADDRESS <u>8 Anchor St Westminster, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEM. GARDENS</u>				23d. LOCATION (City, town or county) (State) <u>FINKSBURG MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>						25. DEC BY REGISTRAR <u>DEC 20 1967</u>					
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on reverse. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>168:1</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>Item d Film G396 1/5/68 kk <b>CERTIFICATE OF DEATH</b> 10005</div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN</u> c. LENGTH OF STAY IN 1b <u>5 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>-----</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>52 BOND ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>FLORENCE BEULAH STARR</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>DEC. 23 1967</u>		<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>FEB. 1 1881</u>				<b>9. AGE</b> (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CARROLL CO. MD.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>ELI J. BUTLER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>FRANCES MILLER</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>-----</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-----</u>		<b>17. INFORMANT</b> Address <u>MR. FRANK T. BUTLER WESTMINSTER MD</u> <u>W. MAIN ST.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1962</u> , 19 <u>  </u> , to <u>12/23/67</u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>12/23/67</u> 19 <u>  </u> , and that death occurred at <u>7 A.</u> M, from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>M.E. Robertson</u>						<b>22b. DATE SIGNED</b> <u>12/23/67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>-----</u>		<b>22d. ADDRESS</b> <u>New Windsor, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>12/26/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WESTMINSTER CEM. WESTMINSTER, MD.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>WESTMINSTER, MD.</u>		<b>24. FUNERAL DIRECTOR</b> <u>J. S. Thompson, WESTMINSTER, MD.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 27 1967</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>-----</u>		<b>26. 21157</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

M										16812										10806									
1. PLACE OF DEATH a. COUNTY										2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE										b. COUNTY									
CARROLL										MARYLAND										MARYLAND									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)										c. LENGTH OF STAY IN 1b										c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)									
NEW WINDSOR										10 MONTHS										WESTMINSTER									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)										d. STREET ADDRESS										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
HORTONS BOARDING HOME																													
3. NAME OF DECEASED (Type or print)										4. DATE OF DEATH										5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
First Middle Last										Month Day Year																			
SAMUEL RAY STEPP										DEC. 11 1967																			
5. SEX										6. COLOR OR RACE										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
MALE										WHITE										JUNE 6, 1881									
8. DATE OF BIRTH										9. AGE (In years last birthday)										IF UNDER 1 YEAR IF UNDER 24 HRS.									
										86 yrs.										Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (County & State, or foreign country)									
LABORER										BY DAY										TENNESSEE									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME										12. CITIZEN OF WHAT COUNTRY?									
WILLIAM STEPP										NANCY WEST										U.S.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16. SOCIAL SECURITY NO.										17. INFORMANT									
No										217-05-4387										Mrs. VELMA FEESER, 13, WESTMINSTER MD.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Arteriosclerotic C.V.D.										INTERVAL BETWEEN ONSET AND DEATH									
4221										DUE TO										year,									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)																			
										DUE TO																			
										(c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
Hour a.m. p.m.										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										(City or town) (County) (State)									
19																													
21. I certify that (I) (this hospital) attended the deceased from 2/25/47, 19 to 12/11/47 19, that (I) (we) last saw the deceased alive on 12/9/47 19, and that death occurred at 11:47 AM, from the causes and on the date stated above.																													
22a. SIGNATURE										22b. DATE SIGNED																			
M. E. Robertson										12/11/47																			
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS																			
M. E. ROBERTSON										NEW WINDSOR, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF										23c. NAME OF CEMETERY OR CREMATORY									
BURIAL										DEC 13, 1967										GREENMOUNT									
23d. LOCATION (City, town, or county) (State)										23e. REC'D BY REGISTRAR										23f. REGISTRAR'S SIGNATURE									
CARROLL COUNTY MD										DEC 14 1967										Charles Judge									
24. FUNERAL DIRECTOR										24a. ADDRESS										24b. REGISTRAR'S SIGNATURE									
D. D. Hutzler & Sons										NEW WINDSOR MD																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>						c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HORTON BOARDING HOME</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ZELMA INEZ STRAWSBURG</u>						4. DATE OF DEATH <u>DEC 16 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>JAN 1 - 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENT FACTORY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WALTER JOHNSON</u>						14. MOTHER'S MAIDEN NAME <u>CLARA BARNHART</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-16-9234</u>		17. INFORMANT <u>RHEA MCKINNEY UNION BRIDGE MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>12/16/67</u> , 19 <u>  </u> , that (I) <u>we</u> saw the deceased alive on <u>12/16/67</u> 19 <u>  </u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>M. E. Robertson</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>						22d. ADDRESS <u>New Windsor, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HAUGHS</u>		23d. LOCATION (City, town or county) (State) <u>LADIESBURG MD</u>			
24. FUNERAL DIRECTOR <u>DD Hartzler &amp; Sons Union Bridge</u>						25a. REC'D BY REGISTRAR <u>DEC 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



16814

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residente before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr 8m 24d</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>12</b>		
3 NAME OF DECEASED (Type or print) <b>Leonard Vallo Vogel</b>			4. DATE OF DEATH Month <b>12</b> Day <b>24</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>2/23/86</b>		9 AGE (In years last birthday) <b>81</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Preston Vogel</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-52-2943</b>		17. INFORMANT <b>Lydia Jane Durbin</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Mental deficiency, idiopathic, severe</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>4/1/67</b>	20f. (City or town) (County) (State)		
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>admission date</b> , to <b>12/24</b> , 1967, that <del>he</del> (she) last saw the deceased alive on <b>12/24/67</b> 19____, and that death occurred at <b>5:40pm</b> from causes and on the date stated above.					
22a. SIGNATURE <b>A. Gonzales</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Gonzales M.D.</b>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Smithsburg, Md</b>		
24. FUNERAL DIRECTOR <b>Mannick Funeral Home</b>		ADDRESS <b>Smithsburg, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>M. J. J. J.</b>



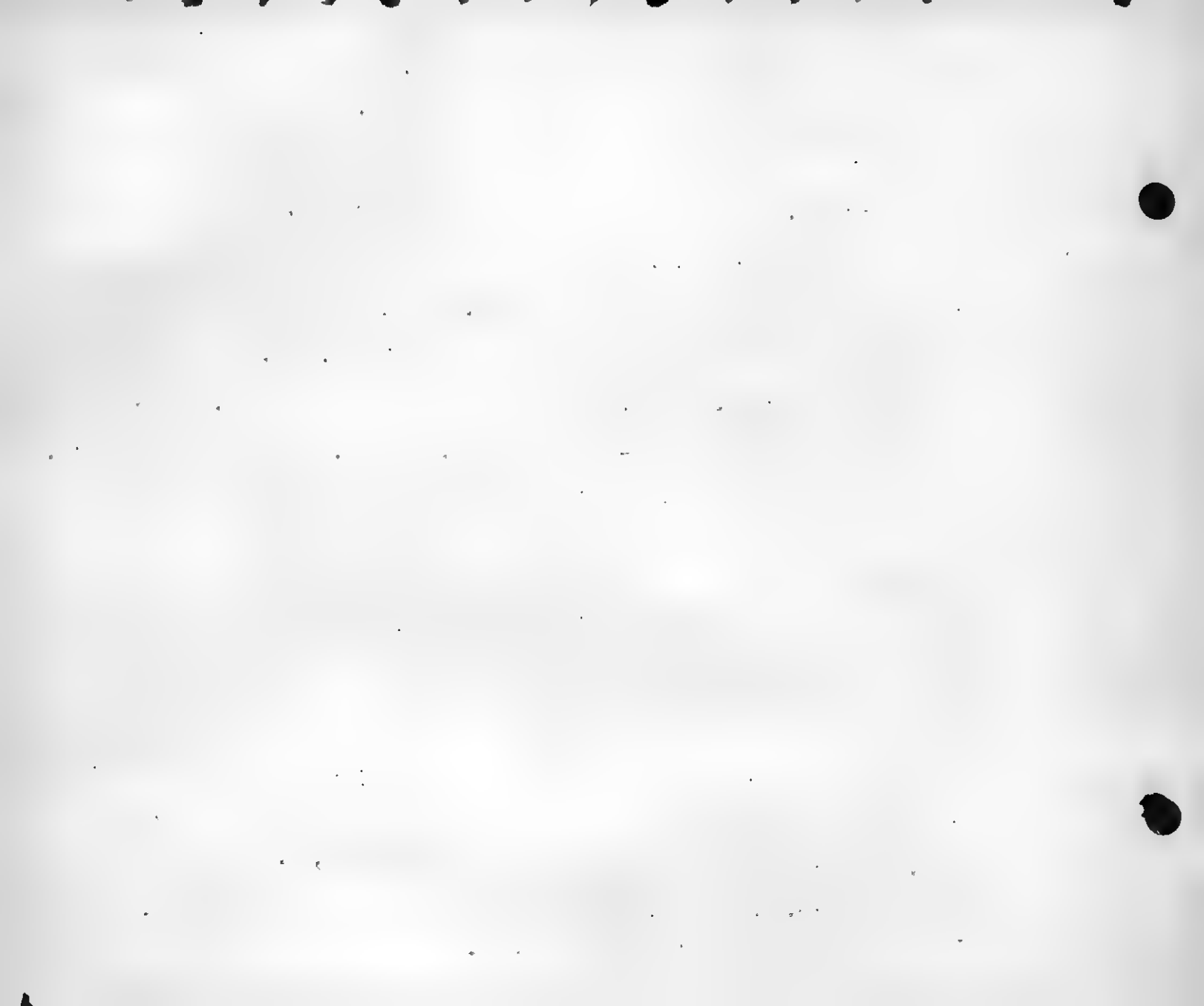


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Manchester</b> c. LENGTH OF STAY IN 1b <b>MANCHESTER</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>200 York St.</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Manchester</b> d. STREET ADDRESS <b>200 York St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Joseph</b> Middle <b>Edward</b> Last <b>Webster</b>				<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>26</b> Year <b>19 67</b>							
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 26, 1885</b>		<b>9. AGE</b> (In years last birthday) <b>82</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Carroll Co. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Charles M. Webster</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha J. Adams</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>220-01-0446</b>		<b>17. INFORMANT</b> Address <b>Mrs. Viola M. Webster Manchester, Md.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic C.V. Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Chronic Emphysema</b>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Aug. 19 59</b> <b>to Dec. 26, 19 67</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Dec 26 19 67</b> <b>and that death occurred at</b> <b>8:30 p.m.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>M.C. Porterfield</b>						<b>22b. DATE SIGNED</b> <b>12/27/67</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>M.C. Porterfield</b>		<b>22d. ADDRESS</b> <b>Hampstead, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>Dec. 30, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Immanuel Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Manchester, Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Tipton - Eline Funeral Home Hampstead, Md.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>JAN 1968</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>[Signature]</b>			



16816

CERTIFICATE OF DEATH

16811

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution an Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RT#3</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL CO. GENERAL HOSPT.</u>		d. STREET ADDRESS <u>FRIDINGER MILL ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>EDGAR TROSTLE WEIGLE</u>		4. DATE OF DEATH <u>12 15 19 67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1905</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>15</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TV. MECHANIC</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN N. WEIGLE</u>		14. MOTHER'S MAIDEN NAME <u>RUFFENIA TROSTLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-01-1763</u>	
17. INFORMANT <u>WAYNE L. WEIGLE</u>		Address <u>308 GAWAIN PLACE ELLICOTT CITY, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>10 DAYS</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>YEARS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>67</u> , to <u>12/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>67</u> , and that death occurred at <u>1:03</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Vincent J. Riocco Jr.</u>		22b. DATE SIGNED <u>12/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. J. S. Myers Jr.</u>		22d. ADDRESS <u>Westminster, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>WESTMINSTER MD.</u>
24. FUNERAL DIRECTOR <u>J. S. Myers Jr.</u>		25a. REC'D BY REGISTRAR <u>DEC 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John H. Jones</u>		DATE <u>DEC 19 1967</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Sykesville</b>		c LENGTH OF STAY IN TB <b>1 mo./26 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e STREET ADDRESS <b>210 W. 25th Street</b>	
3. NAME OF DECEASED (Type or print) <b>Irene NMN WHEATLEY</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <b>Common-law</b>	8. DATE OF BIRTH <b>8-9-16</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>23</b> Hours <b>19</b> Min <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WM. WHEATLEY</b>		14. MOTHER'S MAIDEN NAME <b>JUDY AKERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>?</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>/Pending/ Rt Frontal lobe tumor of the brain</b>			
DUE TO (b) <b>Glioblastoma</b>			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. Glenn Speicher, M.D.</b>		22. DATE SIGNED <b>12-23-67</b>	
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>		23. DATE SIGNED <b>12-23-67</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE THEREOF <b>DEC 27 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL CEM.</b>	23d. LOCATION (City or town) (County) (State) <b>HAYDESGRAVE HARTFORD MD</b>
24. FUNERAL DIRECTOR <b>R. Madison Mitchell, Harold Kiser</b>	25a. REC'D BY REG. STRAR <b>DEC 27 1967</b>	25b. REG. STRAR'S SIGNATURE <b>W. J. Judge</b>	



CERTIFICATE OF DEATH

16813

16812

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Cornell</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cornell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester md</u>		c. LENGTH OF STAY IN 1b <u>1 yr, 4 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Longview Nursing Home Inc.</u>		e. STREET ADDRESS <u>60 Sycamore St.</u>	
3. NAME OF DECEASED (Type or print) <u>Lydia Virginia White</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 23, 1881</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Bigham</u>		14. MOTHER'S MAIDEN NAME <u>Leatha A. Horton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>215-14-2528</u>	
17. INFORMANT <u>Nellie Burton, daughter.</u>		Address <u>123 City View Westminster, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> , 19 <u>66</u> , to <u>12/4</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>12/3</u> 19 <u>67</u> , and that death occurred at <u>4:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Ford</u>		22b. DATE SIGNED <u>12/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Ford M.D.</u>		22d. ADDRESS <u>Manchester, Md 2102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>12/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Westminster Cornell Md.</u>
24. FUNERAL DIRECTOR <u>J. E. Myers, Jr. Westminster, Md.</u>		25a. RECEIVED BY REGISTRAR DATE <u>DEC 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

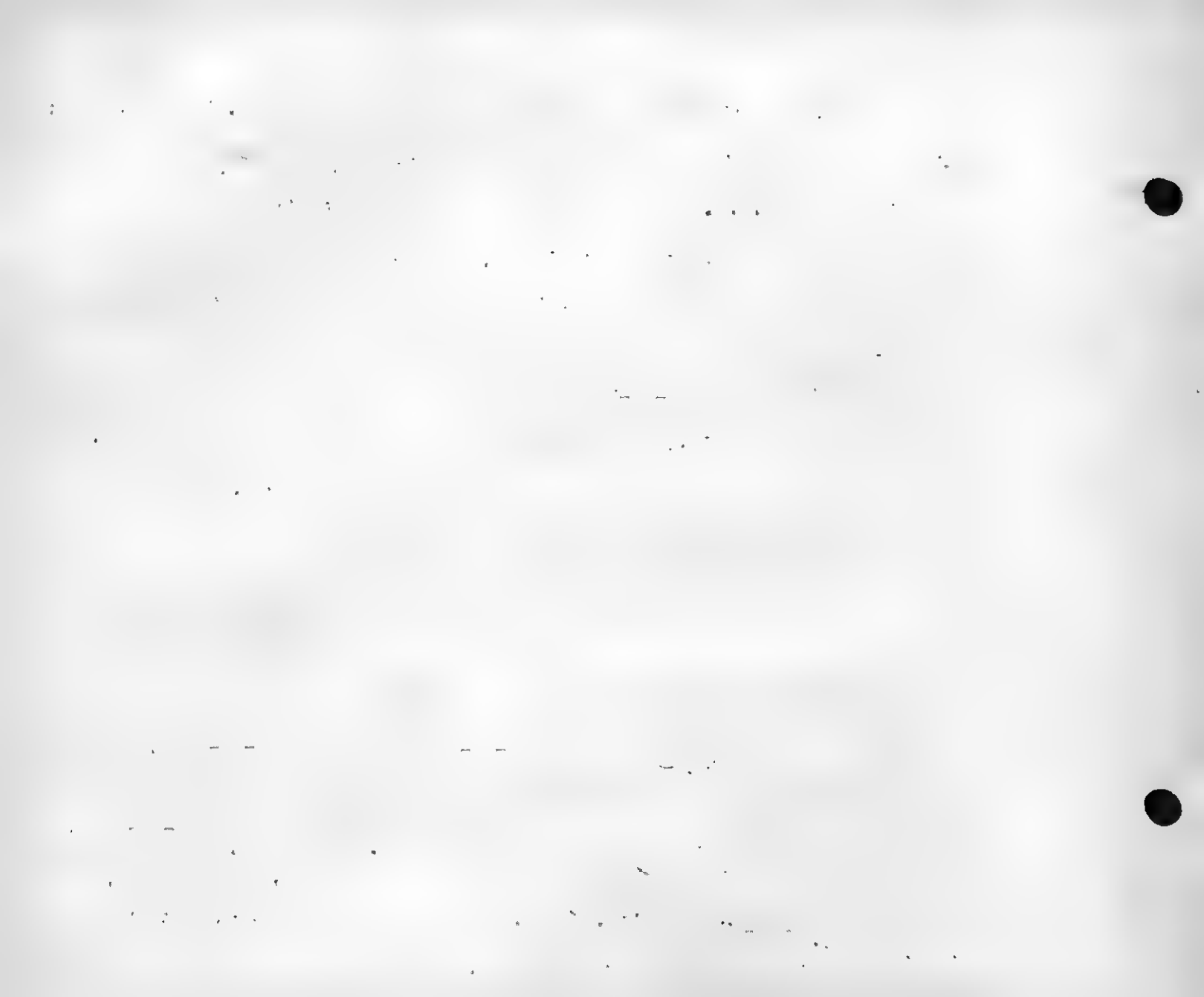




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A
Harold Gregory Whiting						Dec. 25th 1967			2:10 M
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	Negro		8/20/01			66 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH			
Virginia		U.S.A.				Carroll Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hospital			Mechanic			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1709 Harlem Avenue		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Brooks Whiting			Mary Gregory						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
Yes			1918		Hospital Records				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4221</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9-27-</u> , 196 <u>4</u> , to <u>12-25-</u> , 196 <u>7</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12-25-67</u> 19 <u>67</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
<u>Fl. Youzalis</u>						12-26-67			
22d PHYSICIAN'S NAME (Type)		22e ADDRESS							
<u>Fl. Youzalis</u>		<u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		12-29-67		Balto. Nat'l. Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>Bullock Mortuary</u>		<u>714 E. N. Ave.</u>		DATE JAN 2 1968		<u>Judge</u>			



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MEDICAL CERTIFICATION

16820										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										16814																																							
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																																							
First Lottie Middle Lillian Last Wiltshire										12 Month 18 Day 67 Year										6:45am																																							
3. SEX female										4. RACE white										5. DATE OF BIRTH 5/02/94										6. AGE (In years 13 birth day)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Carroll Md.																													
10. CITY OR TOWN OF DEATH Sykesville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife										12b. KIND OF BUSINESS OR INDUSTRY own home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. COUNTY Frederick										13c. CITY OR TOWN Braddock Hgts.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER --																			
14. FATHER'S NAME First David Middle -- Last Hoke										15. MOTHER'S MAIDEN NAME First Charlotte Middle -- Last Ramburg																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no										16b. SOCIAL SECURITY NO. unknown										17. INFORMANT Address Springfield Hospital records, Sykesville, Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure										days																																																	
4221										DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease										years																																							
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
Involutional psychotic reaction.																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that I (this hospital) attended the deceased from 3/27/1967, to 12/18/1967, that (we) last saw the deceased alive on 12/18/1967, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE Naci N. Buyukunsal, M.D.										DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED 12/18/67																																							
22d. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.										22e. ADDRESS Springfield State Hospital Sykesville, Maryland																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial										23b. DATE 12/21/67										23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery										23d. LOCATION (City or Town) (County) (State) Middletown, Fredk, Md.																													
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.										ADDRESS										25a. REC'D BY REGISTRAR DATE DEC 26 1967										25b. REGISTRAR'S SIGNATURE Charles Judge																													



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - New Windsor, Md 29.</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - New Windsor, Md 29.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Nicodemus Road</b>					d. STREET ADDRESS <b>R.F.D. #1 Nicodemus Rd.</b>				
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Irvin</b> Last <b>Woodward Jr.</b>					4. DATE OF DEATH Month <b>Dec</b> Day <b>9</b> Year <b>1967</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13 JAN 1926</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>41</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Security Guard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tinkerton</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mapleshade, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Clarence Irving Woodward Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Lillian Walters</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>KOREAN</b>		17. INFORMANT <b>Mrs. Shirley Woodward (wife)</b>			Address <b>SAME</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ductule CARCINOMA with</b> <b>1962</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Metastasis to liver + spine</b> DUE TO (c) <b>(by biopsy)</b>									INTERVAL BETWEEN ONSET AND DEATH <b>4/67-7/67</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <b>Sept</b> , 1967, to <b>Dec 9</b> , 1967, that (2) (we) last saw the deceased alive on <b>Dec 8</b> , 1967, and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dean H. Griffin</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-9-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dean H. Griffin, M.D.</b>					22d. ADDRESS <b>19 Ridge Rd. Westminster, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>12-12-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>					ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

